Army Regulation 40–68

Medical Services

Quality Assurance Administration

Headquarters
Department of the Army
Washington, DC
20 December 1989

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–68
Quality Assurance Administration

This new regulation--

- Adds the confidentiality statute and the table of organization and equipment treatment facilities (chap 1).
- Adds the impaired provider ad hoc committee (chap 2).
- Expands assessment of patient care, utilization management, and risk management (chap 3).
- Expands privileging and reporting of privileging actions (chap 4).
- Deletes the requirement for a 365-day conditional privileges period for practitioners initially coming on active duty (chap 4).
- Adds dental Activity Quality Assurance Program (chap 5).
- Expands the Quality Assurance Program for Reserve Components (chap 6).
- Adds the quality assurance policies within the Alcohol and Drug Abuse Prevention and Control Program Community Counseling Center Quality Assurance Program (chap 8).
- Adds the preselection procedures for nonmilitary health care providers (app B).
- Adds department of Nursing Quality Assurance Program (app C).
- Adds Nutrition Care Division or Directorate (app D).
- Adds occupational therapy and physical therapy activities (app E).
- Modifies licensure requirements (chap 9).

Headquarters
Department of the Army
Washington, DC
20 December 1989

*Army Regulation 40–68

Effective 19 January 1990

Medical Services

Quality Assurance Administration

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:

MILTON H. HAMILTON
Administrative Assistant to the Secretary of the Army

History. This UPDATE printing publishes a new Army regulation. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. This regulation is a consolidation. It prescribes policy and procedures for the Army Medical Department's Quality Assurance Program which includes—

a. The Impaired Health Care Provider Program.

b. The Alcohol and Drug Abuse Prevention and Control Program Community Counseling Center Quality Assurance Program.

c. Professional licensure.

Applicability. This regulation applies to the Active Army, the Army National Guard (ARNG), and the U.S. Army Reserve (USAR). It also applies to Medical Department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the executive agent.

Proponent and exception authority. Not applicable.

Committee establishment approval. The DA Committee Management Officer concurs in the establishment of the impaired provider ad hoc committee.

Army management control process. This regulation is subject to the requirements of AR 11–2. It contains internal control provisions but does not contain checklists for conducting internal control reviews. These checklists have been developed and will be published at a later date.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. Distribution of this publication is made in accordance with the requirements on DA Form 12–09–E, block number 5027, intended for command level B for Active Army, and A for ARNG and USAR.

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*This regulation supersedes AR 40–66, chapters 9 and 10, 31 January 1985.

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Chapter 1
Introduction

1–1. Purpose

This regulation establishes policies, procedures, and responsibilities for the administration of the Army Medical Department's (AMEDD) Quality Assurance Program (QAP). The purpose of quality assurance (QA) is to—

a. Provide quality care and treatment to all beneficiaries in their need for health services, subject to the availability of space and facilities and the capabilities of the medical and dental staff.

b. Make improvements resulting in higher quality health care.

c. Promote the professional development and enhance the capabilities of the military and civilian members of the AMEDD.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

a. The Surgeon General (TSG). TSG will establish policy concerning the QAP to include reporting requirements.

b. Commanders of major medical commands (MEDCOMs). These commanders are responsible for administration of policies in this regulation, the effectiveness of QAPs in their subordinate units, and for tables of organization and equipment (TOE) units under their command. They will control the extent of patient treatment in the TOE treatment facilities.

c. Commanders of medical department activities (MEDDACs,) medical centers (MEDCENs), and dental activities (DENTACS). These commanders will—

(1) Ensure that a comprehensive QAP is established in compliance with this regulation.

(2) Appoint a QA coordinator (QAC) and risk manager. (See chap 5 for DENTAC.)

(3) Ensure development of a prevention, identification, and procedural plan for impaired health care providers (HCPs).

(4) Ensure coordination of actions under appropriate regulations and the Uniform Code of Military Justice (UCMJ) when necessitated by findings under this regulation.

(5) Ensure that the credentials committee reviews Reserve Component (RC) Army National Guard (ARNG), and U.S. Army Reserve (USAR) practitioner credentials files (PCFs) and takes action per paragraphs 6–4 and 6–5.

d. Chiefs of departments, services, or clinics. In their areas of responsibility, these chiefs will at least—

(1) Retain accountability for all professional and administrative functions.

(2) Develop criteria for granting clinical privileges.

(3) Provide recommendations for granting and renewing clinical privileges based upon the performance of each practitioner who practices in that department.

(4) Evaluate and document the credentials and current competence of HCPs not individually privileged.

(5) Evaluate causes for, and participate in response to, untoward incidents.

(6) Serve as a coordinating point by providing information about hospital and patient care affairs to members of the department.

(7) With the help of relevant support personnel, plan and conduct QA meetings of the department.

(8) Provide for reports to hospital or dental committees as follows:

(a) Quality assurance committee. Data concerning clinical QA issues to include monitoring and evaluation of quality and appropriateness of patient care. (See also para 2–1*a*.)

(b) Credentials committee. Recommendations concerning clinical practice or conduct problems of practitioners.

(c) Others as appropriate.

(9) Counsel and advise individuals and initiate administrative action on questions about clinical competence or performance, disregard for reasonable rules, lack of respect for coworkers, suspected impairment, or practicing outside the scope of clinical privileges that have been granted.

(10) Establish a systematic program for recognizing those within the service or department who make exceptional contributions to the care of patients through clinical competence and/or leadership in the provision of such care.

e. RC commanders. RC commanders are responsible for the administration of policies in this regulation. They are responsible for the effectiveness of QAPs within their commands to include—

(1) Establishing a credentials committee.

(2) Appointing a QAC.

(3) Establishing, reviewing, and maintaining PCFs.

(4) Providing updated PCFs for review by each serviced MEDDAC, MEDCEN, or DENTAC. (See chap 6.)

(5) Approval of privileging actions for assigned or attached practitioners engaged in providing health care during unit controlled activities (for example, physical examinations, immunizations, dental examinations, field exercises, medical support missions, and so forth).

f. MEDDAC or MEDCEN QAC. The QAC is the overall manager of the MEDDAC or MEDCEN QA activities who plans, organizes, coordinates, and evaluates QAP functions outlined in the QA plan. (See para 3–6.)

g. MEDDAC or MEDCEN risk manager. The risk manager is the overall manager of the MEDDAC or MEDCEN risk management (RM) program who plans, organizes, coordinates, and evaluates the risk management functions (para 3–5). The risk manager will also incorporate quality control procedures for medical materiel as part of the overall RM program. (The dissemination of medical materiel quality control information per AR 40–61 is the responsibility of the chief, medical treatment facility (MTF), logistics division.) (See para 3–7.)

h. MEDDAC or MEDCEN credentials specialist. Where this is a separate function (not performed by the QAC), the credentials specialist will initiate and maintain the provider activity files (PAFs) and the PCFs for all MEDDAC or MEDCEN practitioners. There will be coordination with the QAC and risk manager to assure proper information flow. Upon transfer or permanent change of station (PCS) of the practitioner, there will be a timely mailing of the PCF (para 4–3*a*).

i. Community counseling center clinical director. The clinical director carries out the QAP within the community counseling center. (See para 8–2.)

j. The community counseling center (CCC) clinical consultant. The CCC clinical consultant will—

(1) Assist the CCC clinical director in the development of the CCC QA plan.

(2) In coordination with the clinical director, assist in the coordination of the CCC QA plan with the MEDDAC, MEDCEN, or DENTAC QA committee.

(3) Develop criteria for clinical privileges of CCC HCPs with the department, service, or clinic chief appropriate to the profession of the person applying for privileges.

1–5. Objectives of the QAP

The objectives of the QAP are to assure that personnel of MEDDAC, MEDCEN, or DENTAC—

a. Deliver quality patient care subject to the availability of space and facilities and the capabilities of the medical and dental staff.

b. Reduce risk-creating incidents and adverse effects to patients.

c. Improve provider-patient communication and patient satisfaction.

d. Enhance coordination and communication among HCPs and clinical and ancillary services.

e. Improve the HCP screening, selection, and accession process.

f. Objectively evaluate practitioner performance through performance-based criteria and other QA information as defined in this regulation.

g. Educate MEDDAC, MEDCEN, and DENTAC personnel on QAP requirements.

h. Enhance the skills and knowledge of practitioners.

i. Consolidate QA efforts into one comprehensive program.

j. Reduce medical malpractice cases and claims to the maximum extent possible.

1–6. Quality assurance education

Education not only improves the MEDDAC, MEDCEN, or DENTAC clinical, administrative, and ancillary services personnel's understanding of QAP objectives and requirements, it also provides a forum for multidisciplinary discussion of and education on QA issues. Both successful QA efforts and identified problem areas should be communicated to all elements of the activity. Results of QA evaluations will be discussed in department, service, and clinic meetings. Identified areas for improvement will be presented. Trends having educational value or showing a need for changes in policies or procedure should be presented.

1–7. Confidentiality statute

a. Statute. The National Defense Authorization Act for Fiscal Year 1987 (Public Law No. 99–661 (PL 99–661), section 1102, title 10, United States Code (10 USC 1102)) provides that records created by or for the Department of Defense (DOD) in a medical or dental QAP are confidential and precludes disclosure of or testimony about any records or findings, recommendations, evaluations, opinions, or actions taken by the QA activity except in limited situations. These records include any proceedings, minutes, reports, or other records emanating from DOD QA program activities that are produced or compiled by DOD as part of a medical QAP. The statutory privilege is designed to improve the quality of medical care by encouraging a thorough and candid medical peer review process.

b. Statute provisions. The statute—

(1) Establishes the confidential and privileged nature of QA information.

(2) Prohibits disclosure of records and testimony concerning the records except in certain circumstances. (See *e* below.)

(3) Establishes penalties for unauthorized disclosure. (See *g* below.)

(4) Provides immunity from civil liability for anyone who, in good faith, participates in or provides information to a person or body engaged in creating or reviewing medical QA records. (The law specifically provides that QA records may not be "subject to discovery or admitted into evidence. . ." except as provided by statute.) The law does not limit access to information in a record created and maintained outside a DOD medical or dental QA program even though it may be presented to a peer review body and become incorporated into a QA record—for example, a patient's medical or dental record.

c. Inclusion. To receive coverage under this statute, QA and RM activities will be clearly identified. For example, a commander's investigation under AR 15–6 would not normally be a QA function while a QA investigation using for convenience the format of an AR 15–6 investigation would be.

d. QA record. A medical or dental QA record is defined as "the proceedings, records, minutes, and reports that emanate from" QAP activities. A medical or dental QAP is "any activity carried out before, on, or after the date of enactment of this section by or for the DOD to assess the quality of patient care. . . ." The statute specifically includes within the definition of QAP any activity designed to assess the quality of patient care carried out or conducted by individuals; MEDDAC, MEDCEN, or DENTAC committees; or other review bodies responsible for credentialing, infection control, patient care assessment, medical and dental records, health resources management review, and identification and prevention of medical or dental incidents and risks.

e. Exceptions to nondisclosure. The statute allows disclosure of record or testimony to—

(1) Federal or private agencies performing licensing or accreditation functions regarding DOD health care facilities or conducting required monitoring of an MTF or a dental treatment facility (DTF).

(2) An administrative or judicial proceeding commenced by a current or former DOD practitioner concerning the revocation, restriction, or suspension of the practitioner's clinical privileges.

(3) Governmental boards, agencies, or professional health care societies or organizations if needed to perform licensing, credentialing, or monitoring of the professional standards of any present or former member or employee of DOD.

(4) A hospital, MEDDAC, MEDCEN, or DENTAC, or other health care facility to assess the professional qualifications of a current or former DOD practitioner who has applied for or has been granted authority or employment to provide health care services in or on behalf of such institution.

(5) Officers, employees, or contractors of DOD who have need for QA information in the performance of their official duties; including, but not limited to, claims attorneys, claims officers, claims investigators, criminal investigators, and The Inspector General.

(6) Criminal or civil law enforcement agencies or instrumentalities if—

(a) They are charged under applicable law with the protection of the public health or safety.

(b) A qualified representative of such agencies or instrumentalities makes a written request that such record or testimony be provided for a purpose authorized by law.

(7) Protect the public health or safety but only with respect to the subject in an administrative or judicial proceeding brought by a criminal or civil law enforcement agency.

f. Secondary disclosure. The records of the QA activity or testimony given concerning the QA process remain confidential and further disclosure may be made only as specifically provided. This extends to any person or entity having possession of or access to QA records or testimony.

g. Deletion of names. All names included in a QA record, except for the name of the subject of a QA action, will be deleted from the record before disclosure outside DOD. The requirement does not apply to releases under the Privacy Act.

h. Penalty provisions. Penalties range from a $3,000 fine for a first offense of willful and knowing disclosure of a QA record to $20,000 for subsequent violations. The penalty provisions apply to any person who makes an unauthorized disclosure of both authorized and unauthorized releases or who makes further disclosure of the privileged information.

i. Disclosure. In no instance will QA records or information be released to anyone other than AMEDD personnel in the performance of their duties without the written approval of the MEDDAC, MEDCEN, or DENTAC commander. (The commander should consult with a judge advocate or civilian legal adviser concerning questions of releasability.) The following will be included on the transmittal of any QA document: "Quality Assurance Document under 10 USC 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of the law. Unauthorized disclosure carries a minimum $3,000 fine."

j. Processing of requests under The Freedom of Information Act (FOIA). While QA records are exempt from access under FOIA, processing of these requests (with legible copies of requested records) to the appropriate initial denial authority (IDA) is required. The IDA for these records is TSG.

1–8. TOE treatment facilities

This paragraph applies to TOE facilities not operating as a fixed, permanent MTF in peacetime.

a. Patient treatment in TOE hospital units not operating with their complete authorization of TOE personnel and equipment will

be permitted to the extent authorized by major MEDCOM commanders.

b. The commander of the TOE unit will propose a scope of practice for the unit, specifying the extent to which the facility will be operational including proposed staffing during its operation. This will be submitted to the director of health services (DHS) for the area of operations.

c. The DHS and the TOE commander will provide a plan that will include the scope of practice and the professional support and backup required from the fixed MTF. This specific plan will be forwarded for approval to the major MEDCOM commander, addressed to the attention of the deputy chief of staff for clinical services. The major MEDCOM commander will approve, modify, or correct the plan. The major MEDCOM may delegate approval authority to the DHS.

Chapter 2
MEDDAC and MEDCEN Quality Assurance Program committees

2–1. Committees

The complexity of committee organization will depend upon the size and composition of the medical staff and the size and mission of the MEDDAC or MEDCEN. Each separate activity with a Medical Corps (MC) officer commanding will have a QAP. The following QA committees, at least, will be formed:

a. MEDDAC or MEDCEN QA committee.

(1) The QA committee (the executive committee of the clinical staff)will actively participate in the QAP, assuring that quality care is being delivered within the MTF and by the separate activities under its command.Table 2–1 will be used as a guideline for a calendar of reports. Separate activities will also report on a regular basis.

(2) The QA committee will—

(a) Evaluate all practitioners who provide the same patient care service using the same standards to ensure that care will be of the same level of quality.

(b) Approve the MTF written QA plan.

(c) Review patient care evaluation, utilization management, and RM activities to include followup carried out in the MTF.

(d) Have the authority to require corrective action within the parameters of the MTF's mission, policies, and programs.

(e) Notify the MTF executive committee when action is not implemented within a reasonable time.

(f) Integrate and coordinate QA findings, recommendations, and actions. When problems or opportunities to improve patient care involve more than one department or service, the committee will communicate information among departments or services. (See para 3–6*c*.)

(g) Report pertinent findings to the credentials committee.

(h) Determine the overall effectiveness of the QAP at least annually.

(i) Identify resources to implement an effective QAP.

(j) Perform executive committee of the medical staff functions per Joint Commission on Accreditation of Healthcare Organizations (JCAHO) medical staff standards.

(3) The exact composition of the committee should be determined by the commander. However, the committee will consist of a majority of physicians; the chief, department of nursing or representative; the chief, patient administration division (PAD), and/or the medical record administrator; and the QAC. A physician will serve as chairperson. This committee minus those not privileged may, based on individual facility needs, act as the credentials committee (see *b* below).

(4) Copies of all minutes and reports from all QAP activities will be submitted to the MTF QA committee for review, analysis, and further action as necessary. These minutes will contain findings from ongoing monitoring and evaluation of the appropriateness of care and treatment provided to patients.Table 2–1 will be used as a guideline for frequency of reporting. (The QAC will contact departments and services not submitting minutes and reports in a timely manner.)

(5) Problems that are identified and resolutions or opportunities to improve care will be reported as well as the results of activities undertaken to improve that care. Problems and issues requiring further action, together with recommendations, will be reported. Identification of issues not within the province of the reporting entity, including logistical and administrative matters, will also be reported. The minutes, summarizing the MTF QAP activities, to include conclusions, recommendations, and actions taken, will be sent to the MTF's executive committee.

Table 2–1
Calendar of QA review and evaluation reports to the MEDDAC or MEDCEN QA committee

Unit: Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) **Submit:** Feb, May, Aug, Nov.
Unit: Ambulatory care **Submit:** Jan, Apr, Jul, Oct.
Unit: Anesthesia **Submit:** Jan, Apr, Jul, Oct.
Unit: Blood utilization **Submit:** Jan, Apr, Jul, Oct.
Unit: Drug usage **Submit:** Jan, Apr, Jul, Oct.
Unit: Emergency medicine service **Submit:** Monthly.
Unit: Intensive Care Unit, Coronary Care Unit, and special care units **Submit:** Feb, May, Aug, Nov.
Unit: Infection control **Submit:** Feb, Apr, Jun, Aug, Oct.
Unit: Laboratory/pathology **Submit:** Mar, Jun, Sep, Dec.
Unit: Medical record **Submit:** Feb, May, Aug, Nov.
Unit: Medical staff clinical department **Submit:** Monthly.
Unit: Nursing department **Submit:** Feb, Apr, Jun, Aug, Oct, Dec.
Unit: Nutrition care **Submit:** Mar, Oct.
Unit: Occupational therapy **Submit:** Jan, Apr, Jul, Oct.
Unit: Physical therapy **Submit:** Jan, Apr, Jul, Oct.
Unit: Radiology/nuclear medicine **Submit:** Feb, May, Aug, Nov.
Unit: Respiratory therapy **Submit:** Mar, Jun, Sep, Dec.
Unit: Safety **Submit:** Mar, Sep.
Unit: Social work service **Submit:** Feb, Aug.
Unit: Surgical case review **Submit:** Monthly.
Unit: Utilization management **Submit:** Monthly.

b. Credentials committee.

(1) The role of this committee is to recommend to the commander the clinical privileges of practitioners serving within the MEDDAC or MEDCEN and subordinate clinics and facilities. This will include ARNG and USAR members.The committee will also recommend whether practitioners in conditional status should be separated or released from active duty or employment. The committee will establish a mechanism to review credentials and to grant clinical privileges under procedures outlined in chapter 4.

(2) The committee chairperson will keep and control the reports of the committee and the PCFs. Reports and recommendations of this committee will be sent directly to the commander. Local committee privileging recommendations relating to the MEDDAC commander and deputy commander for clinical services (DCCS) will be forwarded to the regional MEDCEN commander for approval. For the MEDCEN commander and DCCS, the recommendations will be sent to the MEDCOM commander for approval. Recommendations relating to the major MEDCOM commanders and Deputy Chiefs of Staff for Clinical Services will be sent to Headquarters, Department of the Army (HQDA) (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(3) The credentials committee should normally be composed of at least the following physicians or designees: The chief of medicine; the chief of surgery; the chief of primary care and/or community medicine or the chief, family practice, as appropriate; and the DCCS. The commander may select for the committee any other appropriate personnel.

(4) When the committee acts upon the privileges of members of other disciplines, or upon the privileges of an HCP as requested by the commander ((9) below), the director or chief of that department or service or designated corps representative, will also be a member of the committee. The DCCS or designated physician representative will serve as chairperson. The chairperson may request a legal adviser (nonvoting). When individual committee members, to include the chairperson, are being evaluated for granting or restricting of privileges, they will not serve on the committee for that portion of the meeting.

(5) The credentials committee meets formally or on call. The frequency of meetings will be determined by the commander and committee workload. Committee meetings will be timed to permit thorough appraisal of practitioners' credentials and prevent expiration of privileges.

(6) Announcement of these sessions will be made in writing no later than 5 working days before the planned meeting date. Direct notification will be made to those practitioners who will be evaluated to update their credentials and make the privileges request available to the committee before the meeting. (A practitioner arriving at a new duty station must apply for clinical privileges immediately but in no case later than 5 duty days.) An on-call session may be scheduled by the chairperson—

(a) To evaluate requests for additional privileges.

(b) To evaluate the credentials of new practitioners to include all RC practitioners requesting privileges.

(c) To reevaluate practitioners who are in probationary or restrictive categories of professional activity.

(d) To consider or make recommendations to the MEDDAC or MEDCEN commander that a practitioner's privileges be suspended, restricted, or revoked.

(e) When directed by the MTF commander.

(7) The committee will not recommend action on a practitioner unless a quorum of members eligible to vote is present. A working quorum is defined as greater than 50 percent of the voting membership. Voting will be carried out by secret ballot. All members of the committee must either vote yes or no. No abstentions are permitted. If a member believes he or she should be disqualified from consideration of a given individual, the member will provide the chairperson with the reason. If excused by the chairperson, the member will be absent from the committee while that individual is under consideration and during the vote.

(8) The total vote cast yes or no in a particular case will be recorded in the committee minutes. Voting by nonpermanent members of the committee is restricted to the determination of privileges to be granted to the members of their respective discipline. Disqualified members will not vote (para 4–9*c*(1)).

(9) While it is important that time limits reflected in this and subsequent chapters are met, no rights will accrue to the benefit of an affected practitioner in an otherwise proper action based solely on any committee's failure to meet such time limits.

(10) The credentials committee will evaluate the quality of care provided by any HCP as requested by the MTF commander.

c. RM committee. (See para 3–5*d*.)

d. Nursing QA activities committee. (See app C.)

e. Nutrition care division QA committee. (See app D.)

f. Occupational therapy and physical therapy QA activities committee.(See app E.)

2–2. Committee activity and reports

a. The activity of the QAP committees will be an ongoing process. Each committee will keep minutes of each meeting. Generally, all minutes will include the following:

(1) Date of the meeting and the time it began and ended.

(2) Attendance (those required to attend, and those who did or did not attend, also their professional positions).

(3) The content of all discussions (divided into old business and new business). Topics of discussion will be highlighted by using uppercase and underlining. Discussions will cover patient care evaluation and fallout evaluation from occurrence screening and results from other required QA activities; for example, surgical case review or blood usage review.

(4) Conclusions (findings), recommendations, and actions taken. If issues are deferred to another meeting, followup will be documented in the next minutes. (Issues will remain on committee agendas until resolved.)

(5) Authorized signature; that is, chairperson or designated alternate.

b. Formal minutes will not (except for the credentials committee) refer to a case in a way that will allow a patient or any of the HCPs attending him or her to be identified (for example, social security number (SSN), patient's register number, or physician's name). A reference number to allow for tracking will be used. The credentials committee minutes will give the names of the practitioners considered before the committee and the determination of their respective clinical privileges (approval, suspension, restriction, or revocation). For the risk manager's reports or committee minutes, see paragraph 3–5*d.*

c. Committee minutes will be kept per AR 25–400.2, file number (FN) 15–1a. Notes and other working papers will be safeguarded; they are to be available only to the MTF QA committee and officially concerned personnel. The appropriate committee chairperson or QAC will be consulted before any records are made available. These notes and working papers will be destroyed as sensitive documents when the evaluation is completed; they will not be kept as supporting papers for review by higher headquarters or other agencies. Department or service QA monitoring reports using established criteria will not be considered working papers. These reports will be sent to the QA committee. (See para 2–1*a*(4).)

d. The committee chairperson will be responsible for developing an agenda of items to be discussed, based on the priority of issues presented. The published agenda for the meeting should be provided to the membership no later than 3 working days prior to the scheduled meeting. An information copy of approved minutes will be provided to each committee member.

e. If statements are made in committee minutes concerning a standard of care, the portion of the minutes dealing with this issue will be shared with all practitioners to whom it pertains through their departmental meetings.

2–3. Impaired provider ad hoc committee

a. The role of this committee is to recommend to the commander

the management of HCPs impaired by medical or psychiatric problems including drug or alcohol abuse or dependence and emotional and behavioral disorders (chap 7). The committee will—

(1) Develop a plan that will incorporate elements of prevention of impairment among HCPs, to include education for all HCPs on impairment and well-being issues.

(2) Recommend procedures for management of impaired HCPs.

(3) Evaluate evidence of impairment of HCPs reported for alcohol or drug abuse or dependence.

(4) Make recommendations regarding the restrictions on clinical practice of impaired HCPs. Recommendations on practitioners will be sent to the credentials committee; recommendations on all others will be sent to the commander.

(5) Monitor the progress of impaired HCPs during treatment and aftercare.

(6) Make recommendations regarding the phased return to full clinical practice after treatment.

b. When impairment is due to drugs and/or alcohol, the committee will review input from treatment, the CCC staffs, the duty supervisor, and the involved department chief. The committee will monitor the HCP's return to clinical practice. (For civilian disclosure, see AR 600–85, para 5–6*c*.)

c. In cases of medical or psychiatric impairment, the committee will review statements of progress and recommendations from both the HCP's physician and duty supervisor and recommend appropriate actions.

d. When an impaired HCP from a particular department is discussed, the department chief of that individual will also be invited, and should be present at the meeting.

e. When a medical evaluation board (MEB) results in a profile limitation or separation, the board should be reviewed for impact on practitioner privileges. If the practitioner is unable to perform fully in his or her granted privileges, appropriate restrictions of privileges will be recommended.

f. The committee members will be designated by the commander and should, when possible, include at least—

(1) The CCC clinical director or the clinical consultant.

(2) Representatives from the departments of psychiatry and nursing(clinical nurse specialist recommended).

(3) A recovering impaired HCP with at least 2 years' recovery.

g. The committee chairperson will ensure that members receive appropriate training to assume the responsibilities of the committee. The committee will meet as necessary to accomplish its required functions.

Chapter 3
Quality Assurance Program

3–1. General

a. The QAP involves an ongoing process to monitor and evaluate objectively and systematically the access to and quality and appropriateness of patient care, pursue opportunities to improve patient care and clinical performance, and resolve identified problems in care and performance.

(1) Quality is the degree of adherence to generally recognized standards of good practice and achievement of anticipated outcomes for a particular service, procedure, diagnosis, or clinical problem.

(2) Appropriateness is the extent to which a particular procedure, treatment, test, or service is efficacious and clearly indicated for the patient.

(3) The components of the QAP are—

(a) Patient care evaluation.

(b) Credentials review and privileging.

(c) Utilization management to include access to patient care.

(d) RM.

b. The QAP is the means by which the components are integrated throughout the MEDDAC, MEDCEN, or DENTAC. Information derived from departmental, service, and clinic monitoring and evaluation is shared with other departments, services, and clinics, as appropriate.

c. A written plan will be prepared for the MEDDAC, MEDCEN, or DENTAC QAP that describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities. As part of the annual reappraisal of the QAP, the QA plan and effectiveness of QA activities of all clinical departments, services, and clinics will be evaluated.

d. All clinical departments, services, and clinics are responsible for monitoring and evaluating the quality and appropriateness of the care or services they provide.

3–2. Monitoring and evaluation process

Clinical department, service, and clinic monitoring will be ongoing, criteria-based, planned, and systematic. They will normally include high volume, high risk, high cost, and problem-prone patient care activities. The essential steps in monitoring and evaluation include the following:

a. Assign responsibility. The chief or director of the clinical department, service, and clinic is responsible for its monitoring and evaluation activities. This person identifies and defines the responsibilities of others in the department and ensures that these responsibilities are fulfilled.

b. Define the scope of care or service. Where direct patient care services are provided, this step involves identifying diagnostic and therapeutic modalities used as well as ascertaining the types of patients served. HCPs then identify the patient care services they provide and the clinical activities they perform.

c. Identify aspects of care. Identify important aspects of care or service for purposes of monitoring and evaluation.

d. Identify indicators. An indicator is a defined, measurable dimension of the quality or appropriateness of an important aspect of care or service. It specifies the patient care activities, events, occurrences, or outcomes that are to be monitored and evaluated in order to determine whether those aspects of patient care conform to current standards of acceptable practice; for example, appropriateness of admission to coronary or intensive care units.

e. Establish thresholds.

(1) Thresholds are pre-established levels or points which, when reached, will trigger intensive evaluation. Monitoring data collected for each indicator will not necessarily lead to a conclusion about the quality and/or appropriateness of care. As data is collected over a series of cases or events being monitored, a pre-established level or point in the cumulative data should be reached that will trigger intensive evaluation. This threshold initiates the evaluation to determine whether an actual problem or opportunity exists to improve care. (All cases or events will be reviewed in this evaluation.)

(2) For example, the threshold for evaluation relating to the wound infection rate indicator may be set at 2.5 percent. Because a certain percentage of wound infections are not preventable even with the best of care, practitioners may find it unproductive to evaluate intensively the quality of care until the threshold is reached.

(3) Although many thresholds may be set at levels other than 0 or 100 percent, some events or occurrences are so serious or so rare that it is not appropriate to accumulate a series of cases or events before evaluating.

f. Collect and analyze data. Data collection will be ongoing. Data will be compared with the pre-established criteria and the information analyzed to detect potential problems, trends, and patterns of performance. Data sources will include but need not be limited to the medical record, medication order forms, incident reports, radiology and laboratory reports, infection control reports, surveys and questionnaires (patient satisfaction or complaints), external peer review reports, observation of personnel or patients, utilization management findings, and RM trending information.

g. Take action on problems. Take actions to resolve identified problems in care and performance or pursue opportunities for excellence. To be effective, corrective action will be appropriate to the

cause of the identified problem. A plan of corrective action should identify who or what is expected to change; who is responsible for implementing action; what action is appropriate, and when change is expected to occur.

h. Assess the actions and document improvement. Corrective actions will be monitored until there is evidence that the problem has been resolved. Monitoring and evaluation activities will also continue to ensure that problem resolution or improvement is sustained, although the timeframe of data collection or evaluation may be changed. The results of continued monitoring and evaluation activities will be documented to provide a record of the efficacy of the monitoring and evaluation process.

i. Communicate information. Relevant findings from monitoring and evaluation activities will be disseminated throughout the MTF, as appropriate. The information will be used in the reappraisal of practitioners for granting or denying clinical privileges (para 4–8*e*) and in the performance evaluation of other HCPs. Where findings have significant applicability outside the facility, they will be communicated to the major MEDCOM.

j. Reports. Department or service QA activities, findings, conclusions, recommendations, actions taken, and results of actions taken will be reported to the MEDDAC or MEDCEN QA committee as shown in table 2–1. (See table 5–1 for DENTACs.) In small, nondepartmentalized MTFs, MTF-wide monitoring and evaluation may be performed.

3–3. Patient care evaluation

The effectiveness of the patient care evaluation functions will be reviewed as part of the annual reappraisal of the MTF QAP and considered during the biennial practitioner privileging process.

a. Medical staff functions. The medical staff will monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all practitioners through—

(1) *Meetings.* Monthly meetings of clinical departments or services to consider findings from ongoing monitoring activities.

(2) *Reviews.* Surgical case review, audit of autopsy reports, anatomic pathology peer review, and invasive procedure review.

(a) Surgical case review. Surgical case review will be performed monthly and include all surgical procedures performed in the operating room, all ambulatory surgery, and all major invasive diagnostic procedures; for example, bronchoscopy and colonoscopy.

1. Pre-operative, post-operative, and pathologic diagnoses will be compared and discrepancies evaluated.

2. Each case in which no tissue or nondiagnostic specimens are removed will be evaluated for the acceptability of or the need for the procedure.

3. The pathologist and medical staff will develop a list of specimens that do not require tissue review; for example, those resulting from newborn circumcision; tooth extraction performed in a hospital operating room, provided the anatomic name or anatomic number of each tooth, or fragment of each tooth, is recorded in the medical record; removal of foreign bodies; or cataract extraction. Cases requiring more intensive evaluation should be identified and specifically documented in committee minutes.

4. When surgical case review consistently supports the justification and quality of individual surgical procedures, the review of an adequate sample of cases is acceptable. When sampling is employed, criteria that define appropriateness of or indications for surgery will be defined and uniformly applied.

5. All cases in which discrepancies have been identified will be evaluated through peer review.

6. When surgical case review is performed for practitioners who are not members of the department of surgery, department chiefs of the affected practitioners will have access to MEDDAC or MEDCEN comparative data for procedures under review.

(b) Audit of autopsy reports. The premortem and postmortem clinical diagnoses and the presumptive and final autopsy diagnoses will be compared for all autopsies. Disagreement among them will be evaluated.

(c) Audit of anatomic pathology peer review.

1. In the audit of anatomic pathology peer review, the tissue review will be accomplished on the basis of routine, periodic, timely sampling of at least 10 percent of all surgical cases from which the tissue samples have been submitted; as close as is possible to 100 percent review should be sought.

2. Peer review of all permanent tissue sections will be accomplished in a timely manner, as befitting the respective individual clinical situation. Peer review of all frozen section diagnoses will be done immediately in any case where major surgery or disfigurement is predicated upon that diagnosis. Where procedures are necessitated at a time when staffing does not exist for immediate peer review of frozen sections, a review of permanent sections will be made as soon as possible and specifically noted in the audit report.

(d) Invasive procedure review. Invasive procedures with potential morbidity will be reviewed for quality and appropriateness. Such procedures will include endoscopies, invasive radiologic procedures, and cardiac catheterizations at a minimum. Review will include comparison of pre- and post-procedure diagnosis and pathologic diagnosis; adverse or unexpected patient reactions and will address patient notification of results.

(3) *Blood usage review.*

(a) The appropriateness of all transfusions of blood and blood components will be reviewed using clinically valid screening criteria. When blood usage review consistently supports the justification and appropriateness of blood use, the review of a random sample of cases is acceptable. (The justification and appropriateness of blood use will be well documented and based on the screening criteria.) Evaluations will include at least—

1. Blood component use.

2. Each confirmed transfusion reaction, to include clinical management. Possible transfusion reactions must be defined by the medical staff.

3. Justification for services. Evaluate crossmatch-to-transfusion ratio; compare type and screen versus type and crossmatch. Single unit transfusions need not be reviewed on a routine basis except where identified as a part of the monitoring and evaluation program. The director of the blood bank will report any suspected abuse or problem to the QA committee.

4. Adequacy of medical staff approved policies and procedures relating to the distribution, handling, use, and administration of blood and blood components. (The blood bank standards in FM 8–70/AFR 160–24/NAVMED P5120 will be used for guidance.) Policies and procedures will be reviewed annually.

5. Adequacy of ordering practices for blood and blood products.

6. When sampling is used, all evaluations (*1* through *5*above) must be accomplished. Sampling must be statistically representative of cases and departments or services.

(b) Examples of screening criteria that may be used are transfusions given—

1. In elective surgery cases where preoperative hemoglobin equals 9 gm or higher (Hct 30 percent or higher).

2. To patients with severe anemia without active bleeding where hemoglobin was 7.5 gm or higher (Hct 24 percent or higher).

3. For active bleeding where estimated blood loss was documented at less than 500 cc.

(4) *Drug use review.*

(a) This review is designed to evaluate prophylactic, therapeutic, and empiric use to ensure that all drugs including antibiotics are used in accordance with guidelines that address appropriateness, safety, and evaluation of effectiveness. Monitoring and evaluating will be performed in cooperation with the pharmacy service, department of nursing, and other departments and services, as appropriate.

(b) To determine classes of drugs for review, consider whether the drugs are—

1. Used in high volume.

2. Known from medical literature (empiric studies) to pose a significant health risk.

3. Known or are suspected to have a high incidence of adverse reactions with significant health risk.

4. Known to cause or be suspected of causing drug interactions with significant health risk.

5. Used in patients who may be at high risk for adverse reactions because of age, disability or metabolic characteristics.

6. Known to be or are suspected of being especially addictive. Also consider any significant drug issues identified through the infection control program or other QA activities.

(c) Examples of antibiotic screening criteria that may be used are as follows:

1. Failure to start using prophylactic cephalosporins 2 to 4 hours preoperatively in elective surgery.

2. Receipt by a patient of two or more antibiotics concurrently or five during a hospitalization.

3. Prophylactic use on a patient 72 or more hours postoperatively.

4. Antibiotic use not based upon laboratory culture and sensitivity.

(d) Drug dispensing errors, drug administration errors, and untoward reactions associated with administered intravenous additive solutions will be properly documented and routinely reviewed as a part of ongoing pharmacy and nursing QAPs.

(e) Drug prescription errors by practitioners will be documented and reviewed (para 4–9*a*(2)).

(5) *Medical record review.* There will be a system for selection of records for review.

(a) Inpatient treatment records (ITRs).

1. A sample of records will be reviewed for clinical pertinence; that is, the degree to which the ITR reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge. ITRs will also be reviewed for timely completion. ITRs will be considered complete when the required contents are assembled and signed. Review will be accomplished in coordination with the patient administration division (PAD), department of nursing, and other departments and services as appropriate.

2. Sampling will represent the full scope and practice of the MTF, reflect special attention to high-volume and high-risk diagnoses and procedures, and include a representative sample of all practitioners within a 12-month timeframe. (See AR 40–66, chap 7.)

(b) Medical record delinquencies. At a minimum, the following delinquencies will be identified:

1. History and physical not done within 24 hours after admission.

2. Operative report not dictated within 24 hours of the completion of surgery.

3. Narrative summary not dictated within 4 working days of patient discharge.

4. ITR cover sheet (worksheet) not completed within 4 working days of patient discharge.

5. ITRs not completed within 30 days of discharge will be attributed to either an individual or an institutional problem. Summation of medical record delinquencies data will be reported on a quarterly basis to the QA committee. Appropriate data will be entered into the PAF.

(c) Outpatient treatment records and health records. Outpatient treatment records (OTRs) and health records (HRECs) will be reviewed for clinical pertinence and completeness; that is, appropriate documentation of visit or episode, up-to-date problem list, and diagnostic test results filed. (See AR 40–66, chaps 5 and 6.)

(6) *Pharmacy and therapeutics monitoring.* Pharmacy and therapeutics monitoring is performed in cooperation with the therapeutics agents board (TAB), pharmacy service, department of nursing, and other departments and services as required. The monitoring includes at least—

(a) The development or approval at least annually of policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials.

(b) Review of the drug formulary.

(c) Evaluation and approval of protocols for use of investigational or experimental drugs, if not accomplished through a clinical investigations committee.

(d) The definition and review of all significant untoward drug reactions. All significant untoward drug reactions will be documented and reported as required by AR 40–2.

b. Anesthesia review. This review includes all important aspects of anesthesia care in any department or service of the hospital, including surgical, obstetrical, emergency, ambulatory, and special procedure units. In addition to implementing appropriate professional or specialty standards; for example, the standards adopted by the American Society of Anesthesiologists, clinically valid criteria will be generated for at least the following indicators:

(1) Appropriateness of choice of anesthetic agent.

(2) Appropriateness of decision to reintubate.

(3) Appropriateness of length of stay in recovery room.

(4) Appropriateness of pre- and post-operative visit documentation.

(5) Anesthesia-related delays in surgery.

(6) Compliance with infection control policies and procedures.

(7) Anesthesia complications and management.

c. Emergency medical services (EMS). (See para 3–7 for use of occurrence screens.) Also, the quality and appropriateness of care in the major functions of the EMS will be monitored and evaluated. Examples of indicators are—

(1) Adherence to protocols or criteria for handling emergencies.

(2) Review of culture results with patient followup to ensure appropriateness of therapy.

(3) Comparison of the final x-ray report with the initial interpretation by the emergency room (ER) physician.

(4) Review of ambulance records for appropriateness of treatment en route.

(5) Compliance with infection control policies and procedures.

(6) Review of referrals.

d. Ambulatory care. The commander will designate the practitioner responsible for assuring that QA activities are implemented.Indicators will include at least—

(1) Appropriateness of diagnosis, treatment, and followup of frequently seen disease entities.

(2) Appropriateness of outpatient care provided pre- and post-hospitalization for patients with chronic illnesses.

(3) Followup of abnormal diagnostic tests.

(4) Availability or radiology, laboratory, and pharmacy services, and the availability of the results of such services in a timely manner.

(5) Control and monitoring of patients on anticoagulants.

(6) Compliance with infection control policies and procedures.

(7) Appropriateness of appointment scheduling (including backlogs)based on the patient's condition.

(8) Followup of patients referred to other facilities to determine that assessment was accomplished in a timely manner.

(9) Followup of the return of OTRs to the servicing MTF to include x-rays of patients referred to other facilities.

e. Special care units. A review of indicators will include at least—

(1) Appropriateness of admission to the unit (defined by written criteria).

(2) Appropriateness of medications and treatment ordered and given.

(3) Appropriateness of request for consultations.

(4) Availability of necessary physician and supporting staff.

(5) Orientation and education programs.

f. Other departments and services. There will be ongoing review and evaluation of activities that are integral to the routine provision of patient care. Critical indicators and criteria, together with thresholds, will be developed by each department and service for the monitoring of patient care. Review and evaluation of preventive and occupational medicine services will include activities integral to patient care and those that may impact on patient care or human health. (See chap 5 for DENTAC, app C for department of nursing, app D for nutrition care division or directorate (NCD), and app E for occupational therapy and physical therapy activities.)

3–4. Utilization management and access to care

The QAP must not only improve the quality of medical and dental

services delivered, it must also ensure access to care and appropriate allocation of the MEDDAC, MEDCEN, or DENTAC's resources by striving to provide the most quality patient care possible in the most cost-effective manner. Where specific services cannot be made available, HCPs will be kept informed of the alternative resources. (Utilization management can create artificial constraints; however, quality patient care will not be compromised.)

a. Utilization management plan. A written plan for utilization management will be prepared to define goals and plans for the year. The overall effectiveness of utilization management will be evaluated annually. The plan will include at least the—

(1) Authority and responsibility of those involved in the performance of utilization management activities to include corrective action.

(2) Description of the methods for identifying utilization-related problems including monitoring activities.

(3) Authority and responsibility of departments, services, and clinics in utilization management.

(4) Required reporting to the QA committee.

(5) Discharge planning mechanism. Criteria for initiating discharge planning will be developed to identify patients whose diagnoses, problems, or psychosocial circumstances usually require discharge planning.

(6) List of diagnoses, diagnosis-related groups (DRGs), procedures planned for monitoring, monitored equipment, and a summary of expected conformance of policies with current requirements (*b* below).

b. Review and assessment. The following are parts of utilization management:

(1) Planned review of care received by inpatients with excessive lengths of stay for diagnoses, DRGs, or procedures. Average lengths of stay will be specified by the MTF.

(2) Review of the accessibility or availability and alternate use of ambulatory care services; for example, outpatient versus inpatient treatment.

(3) Effectiveness of discharge planning.

(4) Use of supplemental care.

(5) Impacts of administrative actions (such as use of leaves and passes, scheduling, subsisting elsewhere, and scheduling medical boards or requests for assignment instructions).

(6) Review of the long-term patient roster. The roster (AR 40–3) will be reviewed each month to determine the appropriateness of medical and administrative management. U.S. military patients who are unlikely to return to duty will be administratively processed promptly and referred to an appropriate health care facility.

(7) Review and justification of all cases of RC personnel who are receiving incapacitation pay and/or continued treatment after the end of the training period.

(8) Review and assessment of resource utilization statistics on accessibility of care, personnel and staffing, and volume of care actually delivered to patients.

(9) Quarterly review of priority listing for equipment on any high-cost procurement (over $10,000 in cost) list.

(10) Annual assessment of high-cost equipment that is over 10 years of age.

3–5. Risk management program

a. RM program. An RM program provides for accident and injury prevention and the reduction of the cost of claims and other financial losses. It encompasses not only the reduction of financial loss to the government but the reduction of risk to patients presented for diagnosis and treatment, and to visitors, family, and MTF personnel. Events will be reviewed that present patient risks although they may not present a risk of financial loss because of ineligibility, expiration of a statute of limitation, or fortuitous lack of damage. Overall effectiveness of the program will be reviewed with the QA committee chairperson at least quarterly.

b. RM program implementation. An RM program will be implemented at every MEDDAC, MEDCEN, and DENTAC.

(1) All serious adverse events, whether or not they are compensable, will be promptly investigated by priority as established by the risk manager.

(2) A system will be implemented that identifies all adverse events. An adverse event occurs when a patient suffers any unintended or unexpected negative result during patient care. Immediate action will be taken to ensure that the patient is protected from additional injury and to mitigate the untoward effects of the event. The patient will be informed by the primary provider of the effects of the event on his or her health and the prognosis.

(3) When an adverse event occurs, the person in charge of the activity where it occurred will ensure that DA Form 4106 (Quality Assurance/Risk Management Document) is prepared and submitted to the head of the department, service, or clinic within 24 hours of the occurrence. If death or life-threatening injury has occurred, the commander will also be notified. DA Form 4106 will be forwarded to the risk manager as soon as possible but in no case later than 48 hours.

(4) Reports of incidents occurring during weekends or holidays will be submitted by 0800 the first normal workday. The report will be factual and objective, giving full details in a concise manner. It will not contain any analysis or speculations about the cause of the adverse event. The chief of the department, service, or clinic concerned will ensure that corrections and followup are made. Each adverse event that requires physician or dentist analysis and RM intervention will be discussed with the chief of the department, service, or clinic concerned.

(5) DA Forms 4106 are QA documents (para 1–7) and accessible to authorized persons only. The forms will be maintained in the risk manager's office per AR 25–400–2, FN 40–407a, and will never be placed in an ITR.

(6) Additionally, all adverse events related to a patient's condition and treatment will be entered on SF 509 (Medical Record—Doctor's Progress Notes) and any other pertinent medical records. The entry should describe any evidence of patient injury and what action was taken for the patient. It should not conclude that an adverse event or accident occurred. Reports of other than patient care adverse events will be reviewed by the safety officer. Such reports will also be referred to other appropriate personnel.

c. Handling of medical records.

(1) In all cases of potential compensable events (PCEs) or Federal tort claims, original medical or dental records will not be released directly to the patient or his or her authorized representative. The medical or claims judge advocate (CJA) or U.S. Army Claims Service (USARCS), as appropriate, will release copies of the records. (This does not apply to cases where the claim is being filed with an individual or agency outside the U.S. Government.)

(2) Original records will not be released unless requested by a Government attorney defending the United States in a malpractice lawsuit. Any such request for medical or dental records must be in writing, specifying the dates of treatment and the names of the MTFs or DTFs involved. The records will be released only per AR 340–21 and AR 27–20. Release of medical or dental records is limited to records defined in AR 40–66 and listed in tables 5–1,5–2, 6–1, and 7–1 therein.

(3) Records kept by various departments, services, and clinics in an MTF or DTF (for example, x-rays, wet tissue, paraffin blocks, microscopic slides, surgical and autopsy specimens, tumor death reports, and fetal monitoring strips) will not be released unless requested by the Litigation Division of the Office of The Judge Advocate General (OTJAG), or USARCS. When these records are specifically requested by the patient or his or her representative, granting such requests will be discretionary with the CJA or USARCS. Original x-rays, paraffin blocks, and slides will not be released.

(4) When medical or dental records are needed for treatment purposes elsewhere, copies or appropriate extracts will be furnished. Prior to the disposition of these records to the National Personnel Records Center (NPRC), USARCS, or Litigation Division, OTJAG (DAJA–LTT), WASH, DC 20310–2210, (AV 225–6435) will be consulted.

(5) Special attention will be given to the handling of medical or dental records involved in litigation or adjudication to ensure accuracy and correlation of evidential documentation. The practices below will be followed.

(a) Prior to any action (for example, photocopy; release to local CJA;transmittal to Litigation Division, OTJAG; or response to subpoena), the original medical or dental record will be reviewed for completion by PAD or the DENTAC and assembled in the appropriate order prescribed in AR 40–66. Assembly will include the attachment of all undersized reports (x-ray reports, laboratory reports, electrocardiogram (ECG) tracings or special tracings) to their respective display or mounting sheets.

(b) Medical or dental records involved in litigation or adjudication require special safeguarding in PAD and will be maintained separately. Complete records filed separately will be accounted for in the central file area with a charge-out guide. Portions of records (for example, reports of special examination) maintained separately will be cross-referenced by an annotation in the basic record (for example, on SF 600(Health Record—Chronological Record of Medical Care)). (See AR 40–66, para 2–5*b*.)

(c) Reproductions must be legible (that is, the print will not be blurred or too light to read). Words and portions of words will not be cut off because of improper positioning of the original copies in the copying equipment. There will be a photocopy page to correspond to every original page.All pages will be numbered consecutively regardless of the number of hospitalizations. (Numbering will be done prior to copying.)

(d) PAD will be the only office in the MTF where official (authenticated) photocopy of a medical record may be made for purposes cited in*(a)* above.

(e) If medical or dental records are released to CJA or USARCS, PAD will append a list to the record identifying signatures and initials appearing in the record. To ensure the capability of identifying authorship of documentation, signature and initial verification lists will be maintained for practitioners involved in medical or dental record documentation. These lists should be recorded on DA Form 4700 (Medical Record—Supplemental Medical Data), and filed in the patient's medical or dental record.

(f) Copies of all correspondence concerning the case will be appended to the record. Copies of correspondence will also be maintained by the CJA.

(g) When medical or dental records have been retired to the NPRC, the CJA or USARCS (not the MEDDAC, MEDCEN, or DENTAC) will notify NPRC not to release the record to the patient or his or her representative. They will also request any records needed from NPRC.

(6) Medical records will be copied and given to the risk manager within 48 hours of the request or as soon as the priority system will allow.

d. RM committee and reports.

(1) An RM committee will be established. It will be multidisciplinary but consist of a majority of physicians, the risk manager, and the CJA. In cases of medical materiel problems, a medical logistician liaison officer will be included. When considered appropriate by the chairperson, the safety officer will also be included. The chairperson will be designated by the commander.

(2) Committee minutes or reports will summarize activities, to include problem trends with recommendations for resolving them, and the status of pending claims and adverse events. The minutes or reports will be processed through the QA committee to the executive committee. Sensitive information will not be included in the minutes or reports but will be kept on file in the risk manager's office. Practitioner specific findings will be reported to the credentials committee.

e. Designated risk manager. A risk manager will be designated in writing at each MTF. The risk manager will be an AMEDD officer with the rank of major or above or civilian equivalent, where possible. (The CJA will not be the risk manager.) The risk manager will have competence in RM standards and policy, general RM administration, basic clinical disease processes, medical terminology, and accident prevention. Competence may be evidenced by appropriate education or by 1 year of practical experience in health care risk management. The risk manager will—

(1) Be a member of the RM committee.

(2) Direct the RM program and report to the QA committee when RM functions are performed by other QAP activities.

(3) Screen adverse events in order to determine whether or not they require physician analysis and RM intervention.

(4) Notify the CJA within 24 hours of identifying a PCE and coordinate further review.

(5) Seek guidance from the CJA regarding explanations of and discussions about the circumstances surrounding the event between staff members and the patient or his or her representative.

(6) Serve as point of contact within the MTF for arranging, scheduling, and coordinating interview of MTF personnel by the CJA or representatives of the USARCS.

(7) Systematically analyze internal hospital data sources (incident reports, medical records, patient care evaluation activities, patient complaints, and so forth) to identify problems and PCEs and determine if adverse events could have been avoided. Other reports such as Inspector General reports will also be used, as authorized by applicable regulations (for example, AR 20–1).

(8) Maintain data (*g* below) including QA investigative reports on adverse events and claims. (See para 4–13.) These data will not be maintained by the patient's name. They should be maintained and cross-indexed by date, department or service, or type of event; for example, failure to diagnose cancer. Report appropriate information concerning medical malpractice claims and settlements.

(9) Coordinate with the QAC.

(10) Incorporate quality control procedures for medical materiel complaints as part of his or her overall risk management. (The chief, logistics division is responsible for the dissemination of medical materiel quality control messages under the provisions of AR 40–61.)

(a) The risk manager must coordinate with the chief, logistics division on all medical materiel problems involving potential Government liability (*i* below).

(b) The chief, logistics division, will ensure that the risk manager and department and service chiefs are immediately notified of all product liability complaints. A followup mechanism will be established by the chief, logistics division, to ensure that appropriate action has been taken on each complaint and that patient safety has been maximized.

(c) The risk manager will provide reports on actions taken by logistics and department and service chiefs to the commander and the RM committee.

(11) Instruct MTF personnel regarding RM policies and procedures.

f. Designated senior physician. A senior physician will be designated in each MTF to provide professional medical consultation to the risk manager and CJA as needed. For example, the senior physician will—

(1) Assist the risk manager in analyzing adverse events.

(2) Provide consultation to the CJA before and during an investigation of the primary medical issues.

(3) Arrange reviews by qualified military and civilian medical specialists.

g. PCE.

(1) When an adverse event is determined to be a PCE by the risk manager after consultation with the CJA, it will be entered into the AQCESS Risk Management Monitoring and Evaluation (events option) Menu with reports archived as support for possible future malpractice cases. In addition to the review, attributions, and disposition, the case will be categorized as follows:

(a) Met standards of care.

(b) Standards of care not met.

(c) Indeterminate.

(2) The degree of injury or disability will be graded as follows:

(a) Moderate. Examples include falls with laceration, appendectomy with a single postoperative episode of sepsis, healed forearm fracture with minor angulation but full range of motion of wrist and

elbow, incisional hernia, loss of one testicle, loss of a portion of a finger (other than index or thumb), and fracture of a tooth during anesthesia.

(b) Severe. Examples include a fall with resultant neurological injury, appendectomy with postoperative intra-abdominal abscess, healed forearm fracture with loss of motion in the wrist or elbow, myocarcial infarction after surgery, evisceration, postoperative inadvertent retention of a foreign body, loss of one phalanx of a thumb or index finger, anesthetic related cardiac or respiratory arrest, and loss of life other than in terminal illness.

h. CJA reporting. The CJA will review and report to USARCS within 72 hours any of the following types of adverse events: (Documentation to be forwarded will be determined per USARCS directives.) (See AR 27–40, chap 5.)

(1) An unexpected or preventable death or significant injury while under the control of the MTF or DTF (not associated with injuries incurred prior to emergency service or hospital admission or a known pre-existing disease).

(2) Any adverse event that either caused, or could cause, injury or death to patients, that in the opinion of the MEDDAC, MEDCEN, or DENTAC commander deserves a QA investigation.

(3) Any cases determined by the CJA that may result in a claim. (These cases will be coordinated with the risk manager.)

i. Requests for information. MEDDAC, MEDCEN, and DENTAC personnel will not deal directly with claimants or potential claimants or their attorneys or representatives without prior coordination with the risk manager, who will coordinate with CJA. All requests for medical or dental information will be referred to the chief, PAD. In these cases, PAD will coordinate with the risk manager who will coordinate with the CJA.

j. Products liability cases. In actual or potential products liability cases, the risk manager will ensure that evidence is preserved.

(1) This includes adverse events in which medical equipment or appliances are involved in an unexpected injury, drug overdose, drug reaction, or an improper prescription. Every effort will be made to preserve the actual equipment (for example, needles, sponges, supplies, drugs, or packages, along with relevant maintenance and purchase and manufacturer's literature). (See AR 27–20, para 2–1.)

(2) Where operating equipment is involved (for example, respirator, suctioning equipment, or equipment controlling the administration of intravenous fluids), the equipment will be removed from service and inspected by a qualified Government employee to determine whether there has been a malfunction or a design flaw, and to decide whether an independent appraisal is necessary. The supplier and manufacturer will be notified and provided an opportunity to inspect (while supervised by a qualified Government employee)the equipment and the actual parts involved. The CJA will be notified prior to any inspection by Government employees, contractor, or supplier employees. The equipment will not be returned to service prior to inspection except where, in the opinion of the commander, medical necessity requires immediate use. Any parts replaced in the equipment involved will be secured by the chief, logistic division, for possible evidentiary use. All original maintenance and purchase records will be secured and photographs taken of the equipment and actual parts involved.

k. Death cases. In cases involving death, immediate attention will be given to whether an autopsy would aid in determining the role of a therapeutic misadventure as the cause of death. The autopsy should attempt to consider all life shortening conditions present. Where necessary, consultation with the Department of Legal Medicine, Armed Forces Institute of Pathology(AFIP), is encouraged. (See AR 40–2, para 4–4.)

l. Adverse event reporting. Any adverse event involving significant morbidity or death will be reported immediately to the next higher headquarters (para 4–9*b*(2)).

m. Malpractice claim. The CJA will provide the risk manager a copy of each claim alleging malpractice at the MTF or DTF. The USARCS will ensure that the CJA for each concerned MTF or DTF receives a copy of each claim alleging substandard care at that facility.

3–6. Duties of the MEDDAC or MEDCEN quality assurance coordinator

The QAC—

a. Monitors all MTF QA activities to ensure that they are ongoing, effective, appropriately documented, integrated with other MTF related programs, and in compliance with Army regulations and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

b. Serves as the primary authority regarding current QA management procedures.

c. Establishes and maintains lines of communication and coordinates and consolidates MTF QA activities.

d. Analyzes and organizes data (practice patterns, trends, and meaningful comparison).

e. Develops a system for filing and tracking QA data, ensuring appropriate confidentiality.

f. Prepares, in coordination with the QA committee chairperson, agenda items for monthly MTF QA committee and executive committee meetings.

g. Maintains the MTF AQCESS.

h. Coordinates with the credentials specialist.

i. Coordinates occurrence screening per paragraph 3–7*b*.

j. Coordinates with the risk manager. Immediately provides RM with all data received in QA activities with known or suspected potential for claims against the MTF.

k. Acts as spokesperson for and promotes active participation in the MTF QAP.

l. Teaches QA methods to all elements of the MTF or coordinates educational programs with departments and services.

m. Ensures that the overall MTF QA plan is reappraised at least annually and recommends appropriate program modification.

3–7. Occurrence screening

Occurrence screening is a criteria-based monitoring of patient medical and dental records in order to identify adverse patient occurrences.

a. MTF- or DTF-generated and generic monitors required by higher headquarters will be used. Attending practitioners, or designated persons, will identify "occurrences found" for each patient at discharge, at the death of the patient, or at the earliest time after an occurrence is identified. The AQCESS occurrence screening checklist should be used. The checklist will be sent to the MEDDAC, MEDCEN, or DENTAC QAC.

b. The MEDDAC or MEDCEN QAC—

(1) Determines which department or service chief or committee chairperson should evaluate the identified occurrence. Following the evaluation, attribution and accountability data will be accomplished and returned to the QAC.

(2) Sends a printout listing these occurrences to the QA committee. In cases attributed to performance of practitioners, the list will also be sent to the credentials committee and to the respective department or service chiefs for appropriate action. (Documentation will be made in the practitioner's PAF). For all HCPs, further actions, ranging from negative findings being reflected on the Officer Evaluation Report (OER) or Enlisted Evaluation Report (EER), to separation or termination of employment will be pursued based on the degree of improvement following intervention. For institutional or corporate findings, the QA committee will forward the findings to the executive committee for management review and action.

(3) Prepares a quarterly and annual summary by clinic service groupings. (The mission template of the MTF will determine the clinic services established in that facility.)

c. The MEDDAC or MEDCEN QA committee monitors compliance with the QAP program. A random audit of at least 10 percent of the records of patients discharged will be performed monthly by designated personnel. Checklists noted to contain inappropriate responses (or where the correctness of a determination is in doubt)

will be referred to the QA committee for review and followup action. (Careful analysis will be accomplished prior to initiating adverse privileging action on the basis of an isolated occurrence. On the other hand, repeated occurrences by a practitioner or particular department or service must receive scrutiny and positive action in order to protect patients from harm.)

d. Occurrence screening applies to all military and civilian practitioners as well as interns, residents, and fellows who, under regulations of the AMEDD, provide medical treatment in Army MTFs. The screening will also be used to identify institutional problems.

e. Occurrence screening does not negate the completion of DA Form 4106 per paragraph 3–5*b*.

3–8. Emergency medical services occurrence screening

Emergency medical services (EMS) occurrence screening will be used. Until necessary personnel are available, the criteria will be used on a rotating basis; that is, one or two per month. Implementation of the AQCESS EMS module is recommended but not required.

3–9. Inpatient discharge survey

Every inpatient will be given the opportunity to complete, at discharge, an evaluation of care received. The locally developed questionnaires will address the following:

a. Promptness of the admission process.

b. Courtesy and friendliness of the admissions staff.

c. Respect for patient privacy.

d. How well staff members identified themselves and explained their purpose.

e. Satisfaction with HCPs, nursing staff, dietary services, and housekeeping services.

f. Experiences with laboratory tests and x-ray or radiology procedures.

g. Whether it is clear that there was a primary care practitioner.

h. Overall rating of patient care received.

i. How well the staff members explained conditions, treatment options, and expected results of the treatments.

Chapter 4
Credentials Review, Privileging, and Proceedings

4–1. General

a. Credentials review and clinical privileging must be effective in order to maintain quality health care. Credentials review includes verification of current licensure, certification, registration (as appropriate), education, training, experience, and current competence. The privileging process is directed solely and specifically to the provision of quality patient care and is not a disciplinary or personnel management mechanism. Privileging actions may, however, accompany actions of an administrative or judicial nature or may engender such actions. In any event, they require independent judgment and fairness.

b. Privileging provides for processing through credentials committee channels those practitioners given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care. This includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, and physician assistants. Also included will be personnel from the following professions when given individual clinical privileges:

(1) Physical therapists.
(2) Occupational therapists.
(3) Audiologists.
(4) Clinical dieticians.
(5) Clinical pharmacists.
(6) Speech pathologists.

c. Other HCPs who function under a standard job description, protocol, or policies and procedures will not be privileged. Department or service chiefs may develop an internal certification mechanism to perform these functions. However, any HCP may be privileged when deemed appropriate by the MEDDAC, MEDCEN, or DENTAC commander. Where full performance of a civil service position requires the incumbent to be privileged, privileging is a condition of employment.

d. Recommendations for granting of clinical privileges will be made by the department or service chief, acted on by the credentials committee, and forwarded to the commander for approval or disapproval. No actions of the credentials committee will be considered final until approved and signed by the commander. In the case of nonphysician practitioners, peer recommendations normally will be obtained in addition to department or service chief recommendations.

e. Practitioners will be granted privileges in the departments, services, and clinics in which they practice, including the emergency room. The clinical director of the Alcohol and Drug Abuse Prevention and Control program (ADAPCP) will be privileged.

f. Granting of clinical privileges will be based on education, specific training, experience, and current competence, taking into account the limitations of the MTF support staff, equipment, capability, and so forth, which may limit a practitioner from carrying out some health care activities. Inquiry will also be made to the National Practitioner Data Bank (para 4–13*f*) prior to initial granting of clinical privileges. In no instance may a person be assigned or privileged to perform professional duties unless qualified by education, training, and experience to perform them. Behavioral competence and health status are also elements in this decision-making process.

g. Reappraisal of defined clinical privileges will be completed at least every 2 years and when a practitioner changes station. (For RCs, see chap 6.)

h. Clinical privileges may be ignored only in the case of an emergency. An emergency is a condition in which the life of the patient is in immediate danger or he or she may be permanently injured if treatment is delayed. In such cases HCPs will be expected to do all in their power to save the patient's life or prevent injury. This includes calling for available consultations.

i. Each department, service, or clinic will develop criteria for granting clinical privileges in that department, service, or clinic.

4–2. Clinical privileges

Clinical privileges are the type of practice activities permitted in the granting MEDDAC, MEDCEN, or DENTAC, within defined limits, based on the practitioner's education; professional license, as appropriate; experience;current competence; ability; judgment; and health status.

a. Staff privileges.

(1) *Courtesy privileges.* These are clinical privileges given to practitioners assigned to the MEDDAC, MEDCEN or DENTAC for short periods; that is, temporary duty (TDY) of 180 days or less. They may also apply to a practitioner located in geographic proximity to an MTF or DTF during military training exercises but not assigned to the facility. These privileges may be granted by the commander of the receiving facility after written or telephonic communication with the practitioner's commander or commander's representative, if appropriate. Courtesy privileges do not apply to ARNG or USAR practitioners.

(2) *Consultant privileges.* These are advisory clinical privileges given to military or civil service practitioners designated as consultants or experts. A PCF will be initiated per paragraph 4–6. The PCF for the civilian consultant or expert will include, as a minimum, DA Form 4691–R (Initial Application for Clinical Privileges), board certification, updated curriculum vitae, letters of recommendation, and verification documentation. DA Form 4691–R is located at the back of this regulation and may be reproduced on 8½- by 11-inch paper. Consultants or experts who provide direct patient care must have formal privileging (para 4–8).

(3) *Temporary privileges.*

(a) These are clinical privileges given to active duty practitioners

when reporting to a new duty station with an incomplete PCF or without a PCF. When a practitioner requests clinical privileges by letter at the gaining MTF without a completed PCF (or the PCF has not yet arrived), the practitioner may be granted temporary privileges by the commander on the recommendation of the chief of the applicable department or service or the DCCS. Temporary privileges do not require review or recommendation by the credentials committee.

(b) The practitioner will sign an acknowledgement of having received and read the MTF medical staff's current rules and regulations and an agreement to be bound by their rules and regulations pertaining to temporary privileges. Temporary privileges may be granted for a stated time not to exceed 30 days. Information on available items of education, training, licensure, and so forth will be obtained from the QA Provider Actions Branch, Quality Assurance Division, Directorate of Professional Services (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258, AUTOVON 289–0088 or commercial (703) 756–0088.

(c) A practitioner with temporary privileges will be supervised by a designated MTF staff member. This supervisor must be privileged and of the same specialty area in which clinical privileges are requested (or any other privileged member of the staff when a specialist in the same discipline is not available). The supervising member must be designated in writing.

(d) Temporary privileges will be used for active duty military practitioners only and will not be granted pending the processing of clinical privileges applications for RC or civilian practitioners. After the temporary period, the practitioner will be placed on provisional status in accordance with (4)*(a)* below. At DTFs, the DENTAC will place the practitioner on temporary status, arrange for supervision, and approve provisional status.

(4) *Provisional (conditional) privileges.* Provisional clinical privileges are given to practitioners newly assigned to a facility or discipline; for example, when they first come on active duty or become employed by the AMEDD, change duty stations, or complete a Graduate Health Professions Education (GHPE) program in a different specialty area.Practitioners who return to clinical practice after serving in a nonclinical capacity (for example, in an administrative or leadership role) for more than 1 year will be given only provisional privileges, regardless of the reason for the nonclinical service, to permit an evaluation of their current clinical competence. Action pertaining to civil service employees regarding performance, training, conduct, and probationary periods will be coordinated with the appropriate civilian personnel office (CPO).

(a) The period of provisional privileges will be 365 days (para 4–4*a*). However, the provisional privileges may be reviewed by the commander and defined privileges granted or other action taken, if appropriate, based on the review. The risks associated with the activities for which privileges are sought and the frequency with which procedures are performed should be taken into consideration.

(b) Failure to attain and retain required proficiency levels for defined privileges by the end of the provisional period will require an evaluation as to whether revocation or permanent restriction of privileges is appropriate. For practitioners completing a GHPE program in a different specialty area and failing to attain proficiency levels, an evaluation to determine privileging in his or her prior credentialed specialty area will also be accomplished. A decision whether to separate the practitioner will be made by the commander following the privileging action (AR 635–100).

(c) During the provisional period, practitioners will be supervised directly or indirectly depending on the recommendations of the credentials committee. The appointed supervisor will submit monthly reports to the credentials committee; however, quarterly reports will be acceptable after three successive satisfactory monthly reports.

(d) RC practitioners whose professional credentials have been reviewed and accepted by the credentials committee for a period of active duty at the MEDDAC, MEDCEN, or DENTAC will be given provisional privileges at each facility where active duty for training (ADT) is conducted. Repetitive ADT at the same facility may result in the facility granting defined privileges based upon credentials committee review and the commander's approval.

(5) *Defined privileges.* These are clinical privileges given the individual by the commander upon recommendation of the credentials committee after completion of a satisfactory provisional period.

b. Privileging actions. Several privileging actions are available to the credentials committee and the commander. (Individuals enrolled in GHPE are controlled by AR 351–3.) (See para 4–8*h*.) The following are privileging actions that may be taken after performances are documented:

(1) *Privilege reappraisal.* (See para 4–8*e* and*f*.)

(2) *Abeyance.* This is the temporary assignment of a practitioner to nonclinical duties while an internal or external peer review is conducted. This period will not exceed 14 days except that the MTF may grant a single additional 14 days by order of the commander. Such abeyance periods are not considered adverse actions with regard to privilege sanctions or reporting requirements.

(3) *Augmentation.* This is the addition of clinical privileges not previously held by the practitioner. Augmentation is based on additional training, sustained superior performance, correction of previously demonstrated deficiencies, or other objective evidence of increased expertise.Reappraisal per paragraph 4–8*e* is required.

(4) *Suspension.* This is temporary removal of all or part of a practitioner's privileges based on incompetence, negligence, or unprofessional conduct, or other factors that do or may affect the appropriateness of the practitioner's privileges.

(5) *Restriction (limitation).* This is permanent removal of a portion of a practitioner's clinical privileges based on incompetence, unprofessional conduct, or other factors affecting the activities restricted.

(6) *Revocation.* This is permanent removal of all clinical privileges. In most cases, such action will be followed by action to terminate the practitioner's DOD service (para 4–4).

4–3. Transfer

a. Practitioner change of station or employment. The credentials committee of the losing MEDDAC, MEDCEN, or DENTAC will send the PCF by certified mail, return receipt requested, to the commander of the receiving facility. The PCF will be forwarded far enough in advance to ensure that it arrives at the receiving facility no later than 15 days before the practitioner's reporting date. If the gaining facility has not received the PCF upon the practitioner's arrival, the facility will take immediate steps to locate the missing PCF. Temporary privileges may be granted to the active duty practitioner (para 4–2*a*(3)).

b. Administrative position or school. If the practitioner changes station to a position involving no clinical practice or attends a civilian or military school (other than graduate medical or dental education), the PCF will be sent to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. These files will be held until requested. (The PCF may be requested by a collocated MEDDAC, MEDCEN, or DENTAC if the practitioner engages in clinical practice while attending school.) For those attending military graduate medical or dental education, the PCF will be forwarded to the military facility conducting the internship, residency, or fellowship training.

4–4. Practitioner's separation

a. Military.

(1) A military practitioner who is not in compliance with this regulation may be eliminated from the service under the provisions of AR 635–100 or AR 135–175.

(2) Active duty members leaving the service in a less than fully privileged status will not receive an appointment or assignment in an AMEDD branch of the RCs.

b. Civilian practitioners. A civilian employee's failure to attain or to maintain the required proficiency levels and the ability to practice may be a basis for separation since the employee is not qualified to retain his or her appointment to the position. Commanders may consider separation under three approaches, each of which requires close consultation with the servicing CPO.

(1) *Separation during probation.* If the practitioner is serving under a probationary appointment (initial competitive appointment, typically a 365-day period), the practitioner may be separated under the provisions of Federal Personnel Manual (FPM), chapter 315. Such an action must be completed before the end of the last duty day prior to the practitioner's 365th day after appointment. For practitioners who are under probation, this is the preferred route, and warrants close scrutiny of employees during their first year of employment.

(2) *Separation based on performance.* This approach is based on poor performance of one or more critical elements in a practitioner's performance plan, and need not include a loss of privileges. This action is taken under the provisions of section 4303, title 5, United States Code and FPM, chapter 432. There are significant rights to notice, opportunity to improve, and to seek external review.

(3) *Separation based on loss of qualifications.* This approach is based on the fact that the practitioner is no longer qualified to perform the duties of the position to which he or she was appointed, or when misconduct or malfeasance serve as a basis. (The misconduct must be related to the practitioner's ability to perform the duties of the position—the "nexus" requirement.) There are significant rights to notice, hearing, representation, and appeals beyond the agency.

4–5. Cross-servicing of practitioners' credentials files

PCFs will be provided as supporting documentation for those practitioners who request interservice transfers. These files will be certified copies and will be added to the transfer request by the practitioner's MEDDAC, MEDCEN, or DENTAC commander. Credentials files of applicants not selected for AMEDD service (preselection credential review) will be made available to recruiting agencies of the other Services on request.

4–6. Preselection credential review

a. Verification. Prior to appointment to the military, civil service, consultant status, foreign national local hire, or as a contract practitioner, a verification of education, training, experience, licensure and/or certification and/or registration, and current competence will be completed. (See para 4–13*f*.)

b. PCF. Information will be obtained so that a PCF can be initiated. (This information will serve as the basis of the PCF throughout that practitioner's service career, or for nonmilitary health care practitioners the entire period they work within the AMEDD.) Following is the information needed:

(1) Copies of qualifying education degrees (including diplomas) needed for the performance of clinical privileges and verification of the authenticity of these documents (para 4–6*c*).

(2) Copies of required postgraduate training certificates for the privileges in the area of work; for example, internship, residency, fellowship, nurse anesthesia school, and verification of the authenticity of these documents.

(3) Copies of State licenses and current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification when applicable. A list of all licenses ever held will be provided along with an explanation of any that are not current or that have ever been subjected to disciplinary action, and a statement that this list with explanations is complete and accurate. There will be verification of licenses and certificates.

(4) Copies of specialty board certificates and fellowship certificates and verification.

(5) A curriculum vitae to account for all periods of time subsequent to obtaining the initial qualifying degree.

(6) Proof of current (within 1 year) competence (letters of reference and a recent description of clinical privileges as concurred in by the supervisors of the practitioner per *c*(5) below).

(7) A statement of involvement in malpractice cases and claims to include a brief description of the facts of each claim settled on the behalf of the practitioner.

(8) Any history of disciplinary action by hospitals, State licensure boards, or other government agency.

(9) A statement regarding physical and mental health to include any history of drug or alcohol abuse.

(10) An interview summary by at least one Medical Corps (MC) officer on active duty (applies to MC only).

(11) All current and prior Drug Enforcement Agency (DEA) numbers, as appropriate.

(12) National Practitioner Data Bank query.

c. Verification.

(1) Preselection verification of military (para 4–6*b*) will be completed by the AMEDD Officer Procurement Division, U.S. Army Health Professional Support Agency (SGPS–PD). Verified copies of all the documents along with DA From 71 (Oath of Office—Military Personnel) and a copy of orders will be sent to the first MEDDAC, MEDCEN, or DENTAC to which the practitioner is assigned. A duplicate packet will be given to the appointee. (These documents will serve as the basis of the PCF throughout the practitioner's service career.)

(2) Before selection of Civil Service, civilian consultants (experts), and foreign national local hires, there will be a preselection verification of education, training, experience, licensure and/or certification and/or registration, and current competence. (See para B–5.)

(3) For verification of education; training; licensure and/or registration, and/or certification; ECFMG; and board certification, if applicable, either an original letter from the educational institution or certifying body, attesting to successful completion of specialty training, or verification by telephone communication between the recruiter and the education institution or specialty board will be used. Telephone verification will be recorded on the document itself and on official letterhead and signed and dated by the individual making the phone call. These letters will be placed in section VI of the PCF.

(4) If the medical or dental diploma has been issued by a foreign medical school in a country that has no diplomatic relations with the United States, the MEDDAC, MEDCEN, or DENTAC will contact HQDA (SGPS–PSQ) (AUTOVON 289–8000; commercial (703) 756–8000) for verification.

(5) For verification of experience and current competence at least two letters of recommendation from appropriate sources in *(a)*, *(b)*, and*(c)* below are required. The letters will be mailed by the author directly to the recruiting agency, MEDDAC, MEDCEN, or DENTAC. These descriptions of recent clinical privileges will be verified.

(a) A letter from either the chief of staff of the hospital, the clinic administrator, the professional supervisor, or the department head, if the appointee has professional or clinical privileges or is associated with a hospital or clinic.

(b) A letter from the director or a faculty member of the appointee's training program, if the appointee has been in a training program within the last 5 years.

(c) A letter from a practitioner (in the appointee's discipline) who is in a position to evaluate the appointee's professional standing, character, and ability; for example, a peer or a president or secretary of the local professional society. A letter from a peer and a professional association or society association is mandatory if the appointee is self-employed.

(6) A copy of the appointee's Federal narcotics license, if applicable, will be submitted and verified with the DEA. The capability of prescribing unrestricted drugs will be determined.

d. Contract practitioners. Civilian contract practitioners must meet the same requirements as civil service practitioners (*c*(2)above). For verification of education, training, and experience, see paragraph B–4.

e. Privileging. Granting of clinical privileges will be withheld until sufficient verified data to document training, experience, and current competence is available.

4–7. Preselection experience and reference checks

a. The following are general guidelines for HCP experience or reference checks:

(1) Always verify by telephone any reference information obtained in writing.

(2) In general, do not limit reference checks to those given by the provider on the application form. Providers must be notified that other individuals may be contacted.

(3) If possible, ask current MEDDAC, MEDCEN, or DENTAC staff and/or peer members to make telephone calls to other HCPs or peers for reference checks.

b. The following are physician applicant contacts for reference(comparable contacts can be made for other HCPs):

(1) For physician applicants now in practice—

(a) Start with the names specified by the applicant on the application form.

(b) Call the chief of staff of the present hospital where the applicant holds staff privileges and previous hospitals where the applicant held staff privileges.

(c) Call the chief of the department of the present hospital where the applicant practices, if appropriate.

(d) If the physician applicant is a member of a medical staff with fewer than five members, call the president of the local medical society. Ask the president for another reference.

(e) If the applicant has been in practice less than 5 years and the previous information is not satisfactory, contact the director of the applicant's residency program.

(f) If problems regarding the physician's relationship with other professionals are suspected, contact the director of nursing of the present hospital or a nursing supervisor of the unit most frequently used by the applicant.

(2) For physician applicants completing residency programs—

(a) Use the names specified by the applicant on the application form.

(b) Always call the director of the residency program.

(c) Ask the director for one faculty person and one attending physician not recommended by the applicant.

c. Use the following questions for experience and competence checks as appropriate (comparable questions can be asked for HCPs other than physicians):

(1) Did you personally ever have reason to question the physician's medical or surgical competence? If yes, ask for an explanation.

(2) Are you aware of committees of the medical staff ever considering or actually taking action against this physician for poor medical practice?

(3) Have you heard concerns expressed by the medical staff over the quality of this physician's practice? If yes, ask for an explanation.

(4) Does the physician work well with other members of the medical staff? If no, ask for an explanation.

(5) Do you and other members of the medical community consider this physician a medical staff leader? If no, ask for an explanation.

(6) Does the physician relate well and in a professional manner with members of the hospital employee staff? If no, ask for an explanation.

(7) Does the physician have, or has he or she had in the past, any personal problems (for example, alcoholism or drug abuse) that have interfered with the professional practice? If yes, ask for an explanation.

(8) Has the physician ever lost admitting privileges because of failure to comply with medical staff bylaws or rules and regulations? If yes, ask for an explanation.

(9) Does the physician complete medical records in a timely and careful manner? If no, ask for an explanation.

d. Records for each contact must be maintained, including names of all parties to the call, date, and summary of the call. OF 271 (Conversation Record) may be used. Contacts should be advised that the practitioner may be provided with this information.

4–8. Clinical privileging

a. Initial application for privileges.

(1) DA Form 4691–R and DA Form 5440–R-series (Delineation of Privileges—Specialty) will be completed upon arrival at the initial duty station or place of employment. The forms will be completed in duplicate. The originals will be given to the PCF custodian and the copies to the practitioner. The specialties listed below are applicable. (See app A for the corresponding DA Form 5440–R-series number.) DA form 5440–R-series will be reproduced locally on 8½- by 11-inch paper; copies for reproduction are located at the back of this regulation.

(a) Anesthesia.
(b) Dentistry.
(c) Family practice.
(d) Internal medicine and subspecialty.
(e) Neurology.
(f) Obstetrics and gynecology.
(g) Optometry.
(h) Pathology.
(i) Pediatrics.
(j) Podiatry.
(k) Psychiatry.
(l) Psychology.
(m) Radiology/nuclear medicine
(n) Surgery.
(o) Nurse anesthetists.
(p) Nurse midwives.
(q) Nurse practitioners (adult).
(r) Obstetrics/Gynecology (OB/GYN) nurse practitioner.
(s) Physician assistants.
(t) Dietetics.
(u) Occupational therapy.
(v) Physical therapy.
(w) Emergency medicine.
(x) Aviation medicine.
(y) General medical officer.
(z) Troop medical clinic physicians.
(aa) Troop medical clinic dentists.
(ab) Troop medical clinic physician assistants.

(2) Prior to the granting of provisional clinical privileges at the appointee's first duty station or place of employment, the MEDDAC, MEDCEN, or DENTAC credentials committee will review the preselection validated documents (para 4–6) and completed DA Forms 4691–R and DA Form 5440–R-series. Based on this review, the credentials committee will forward its recommendation for clinical privileges to the facility commander.

(3) If the appointee disagrees with the MEDDAC, MEDCEN, or DENTAC commander on the initial privileges to be granted, he or she may appeal per paragraph 4–10. Pending appeal findings, the privileges, if any, will be as granted by the MEDDAC, MEDCEN, or DENTAC commander.

b. DA Form 4691–R. DA Form 4691–R provides a synopsis of education and experiential background of each practitioner at the time of initial application for clinical privileges. It includes professional education, postgraduate training, previous hospital assignments, certification and professional society membership, and credentials action history. Form 4691–R is completed only at the practitioner's initial duty station or place of employment.

c. DA Form 5440–R-series.

(1) DA Form 5440–R-series will be used for granting of clinical privileges for practitioners in one of the specialties listed in a above. These forms combine a categorical (patient risk and training of practitioner) and disease and procedure-based (listed specifically) approach by discipline.

(2) For the nonphysician practitioner serving in an expanded role, only the disease and procedure approach is used. When using this disease or procedure-based method, care must be taken to ensure that the practitioner has credentials to perform each function or procedure and that he or she recognizes every hazard or complication for the condition or procedure. The practitioner will complete the left-hand column, initialing the category and privileges requested. The department, service, or clinic chief will initial the right-hand column. The credentials committee chairperson will complete the "Recommendations" portion on the last page. The last page

will be dated and signed by the department, service, or clinic chief; the credentials committee chairperson; and the MEDDAC, MEDCEN, or DENTAC commander.

(3) For practitioners who are assigned to one department or service and request privileges in another, appropriate chiefs in both departments or services will be named and will initial on the last page. The practitioner will document any education or training that was taken since completion of DA Form 4691–R or the last DA Form 5440–R-series. This education or training will be verified by the credentials specialist (para 1–4*h*). (See para 4–11*a*(4)(*a*).) When privileges are modified from those requested, state the reason under "Remarks." (Examples of such reasons are lack of technological resources (will be included on updated DA Form 5440–R-series), lack of ancillary staff, AMEDD unauthorized privileges, lack of practitioner credentials, and professional performance.) When appropriate, only the last page of DA Form 5440–R-series will be completed for a privilege status change; that is, provisional to defined status.

d. DA Form 5440–22 (Delineation or Privileges). This form is completed for those specialties and expanded role functions not otherwise included in the DA Form 5440–R-series; for example, for a dermatologist. This group of practitioners includes all of those identified in paragraph 4–1 but not specifically listed in *a* above. This is a special form and whenever used a copy will be forwarded through the next higher medical headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

e. Periodic clinical privileges reappraisal (renewal).

(1) Practitioners will be continuously monitored to ensure that quality patient care is given. It is the responsibility of each practitioner to request, in writing, the renewal of his or her privileges every 2 years. The request for renewal must be submitted far enough in advance to permit an evaluation of clinical privileges. Thorough reappraisal will be based on education, training, experience, appraisals of clinical performance, PAF data, professional conduct, and health status. Failure to request renewal in a timely fashion will result in the expiration of prior privileges granted, effective on the date that is 2 years from the date the earlier privileges were granted. (See para 4–13*f*.)

(a) DA Forms 5441–R-series (Evaluation of Privileges—(Specialty)) and DA Form 5374–R (Performance Assessment) will be used for the reappraisal of clinical performance. (See app A for a complete listing of the DA Form 5441–R-series.) DA Form 5374–R and DA Form 5441–R-series forms will be reproduced locally on 8½- by 11-inch paper; copies of these forms for reproduction are located at the back of this regulation.

(b) The "privileges performed" on DA Form 5441–R-series (including DA Form 5441–23–R) must be identical to the "privileges delineated" on DA Form 5440–R-series. (See *a*(1) and *d* above.)

(c) When privileges are modified because of the reappraisal, state the reason under "Comments" on DA Form 5441–R-series.

(2) DA Form 5374–R will be used to evaluate clinical and interpersonal professional skills. It will be completed by the chief of the department, service, or clinic. It will include documentation of the results of peer review especially with regard to superior or substandard performance.

(3) At the time of privilege reappraisal, the current PAF data may be removed and destroyed only after the credentials committee judges that the data are reflected accurately and completely in the current reappraisal and privilege delineation. (In no case will data, documents, or other materials placed by another MEDDAC, MEDCEN, or DENTAC be deleted from the PCF. No material relating to a command reprimand, privilege restriction, suspension, or revocation will be deleted.)

(4) If the practitioner disagrees with privileges granted, he or she may appeal per paragraph 4–10.

(5) For the practitioner changing from provisional to defined privileges, a summary of the appointed supervisor's reports (para 4–2*a*(4)(*c*)) will be documented in the "Remarks" section of the appropriate DA Form 5440–R-series.

(6) RC. (See chap 6.)

(7) DA Forms 5440–R-series, 5441–R-series, and 5374–R will be completed in duplicate. The originals will be kept in the practitioner's PCF and copies given to the practitioner.

f. Modification of privileges at the request of the practitioner.

(1) When the practitioner requests modification of his or her clinical privileges for the upcoming period, this fact will be documented in the "Remarks" section of the DA Form 5440–R-series prepared for the period. Practitioners who request privileges substantially less than those that would be expected from members of their specialty area of concentration (AOC) or skill identifier (SI) will be referred to the commander for appropriate administrative action; for example, change in AOC or SI, change in special pays, or separation. (Practitioners who refuse to request privileges within 5 duty days of reappraisal date, PCS, and so forth will be referred to the credentials committee for recommendation of action to the commander.)

(2) If the modification reduces his or her privileges, the credentials committee will—

(a) Determine whether the request is warranted.

(b) Determine whether the practitioner will undergo a period of training. If the training is approved, the modification of privileges-(temporary) will not result in an adverse privileging action.

(c) Determine whether a recommendation should be made to change the practitioner's AOC or SI.

(3) Consider recommending processing for separation in a less than fully privileged status.

g. Practitioners changing duty station or transferred employed civilian practitioner.

(1) When practitioners change stations or transfer, they will submit the appropriate DA Form 5440–R-series to the recceiving credentials committee The losing MEDDAC, MEDCEN, or DENTAC will complete a new DA Form 5441–R-series and DA Form 5374–R. If the biennial appraisal was completed by the losing facility within 6 months of PCS, it will be considered to be current. The credentials committee of the losing facility will send these forms together with the PCF by certified mail, return receipt requested, to the receiving facility. (See para 4–3*a*.)

(2) The gaining facility will use this file as a basis on which to grant provisional privileges. Even if practitioners change stations to leadership or administrative positions involving no clinical practice or become school attendees (para 4–3*b*), the PCFs will include current reappraisals (DA Forms 5441–R-series and 5374–R).

h. GHPE.

(1) Interns, residents, and fellows will be supervised by practitioners who have defined privileges in their AOC or SI. The degree of supervision (direct or indirect) will be appropriate to the individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. Concurrent consultation should be obtained for all patients where a substantial risk is implied or where the diagnosis is obscure. This consultation will be documented on SF 509 or SF 513 (Medical Record—Consultation Sheet). Situations that require mandatory direct supervision will be identified by the program director in writing, and the documentation will be given to those involved.

(2) Training credentials files (TCFs) and PAFs will be developed and maintained for all practitioners during GHPE training. The TCFs will be initiated during the first year of training and contain verified copies of diplomas, licenses, clearinghouse reports, training certificates, practice experience documents (curriculum vitae) and other documents as appropriate. The TCFs will be maintained by the director of education or as directed by the commander. Performance assessments will be made at least every 6 months and a specific recommendation from the department chief for or against promotion to the next year's training level will be made yearly. These will be placed in the PAFs.

(3) Prior to completion of the training program, trainees will submit applications for clinical privileges (DA Form 5440–R-series) through the service chief and the department chief to the professional education committee. One month prior to completion of the training, the education committee will complete DA Form 5441–R-series in response to the application and DA Form 5374–R, which

will show clinical privileges warranted at the resident's first assignment, based on performance during training. The DA Forms 5440–R-series, 5441–R-series, and 5374–R will become permanent parts of the TCFs and sent by certified mail, return receipt requested, to the gaining facility to arrive 15 days prior to PCS. The education committee will decide which, if any, of the interval performance assessments and PAF data from the training period will remain in the TCFs.

(4) In any case where a practitioner is held back or removed from a program for lack of competence or disciplinary reasons, the facts will be reported per paragraph 4–9*k*.

(5) Reporting requirements concerning substandard performance or unprofessional conduct will be made per paragraph 4–9*k*.

i. Formal on-the-job training (OJT). OJT programs consist of formal training to provide expertise in an AOC or SI to individuals who are expected to receive limited privileges in an AOC or SI. The commander will require a written program of instruction, specifying the objectives of the program.

(1) OJT trainees will be supervised by practitioners who have defined privileges in their AOC or SI. The degree of supervision will be appropriate to each individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. Concurrent consultation should be obtained by the trainee for all patients where a substantial risk is implied or where the diagnosis is obscure. Situations that require mandatory direct supervision will be identified by the program director in writing, and the documentation will be given to those involved.

(2) Individuals progressing unsatisfactorily will be processed per the training program procedure.

(3) One month prior to completion of training, the preceptor will complete DA Forms 5441–R-series and 5374–R, which will show those clinical privileges warranted at the individual's next assignment, based on performance during training. These forms will be forwarded through the education committee where one exists, otherwise through the credentials committee, to the gaining facility. They will be sent by certified mail to arrive 15 days prior to PCS. The gaining facility will use this information as a basis on which to grant provisional privileges. These forms will become a permanent part of the individual's PCF.

j. Privileging for new medical procedures and technology. The privileging process remains the same. Particular attention will be given to the details of training, experience, competence, and MTF or DTF capabilities in granting privileges in the use of recent technologies and equipment.

(1) *New procedure.* Prior to the introduction of a substantially new and innovative procedure into an MTF or DTF, the commander will ensure that criteria are developed at the department level and approved by the credentials committee. The criteria will include the specific preparatory training that practitioners must have completed prior to being granted the privilege. The privileging process for a new procedure will be accomplished prior to its introduction.

(2) *New technology.* MTFs and DTFs will ensure that their technology; for example, lasers, and magnetic resonance imaging (MRI) devices, does not surpass the staff's abilities. MTFs will establish safety protocols for an instrument's use and provide for proper privileging procedures. Adverse outcomes involving equipment malfunction will be reported immediately to the risk manager (para 3–5*j*).

k. Musculoskeletal manipulations. Musculoskeletal manipulations consist of palpation and other manual techniques used predominantly by osteopathic physicians. These manipulations are used to evaluate and correct somatic dysfunctions that impair or alter functions of the somatic systems. These include the skeletal, arthrodial, myofascial, vascular, lymphatic, and neural systems. This policy does not provide guidance on joint mobilization that physical therapists commonly use and that do not exceed the normal range of motion of joints. The following policy guidance applies to musculoskeletal manipulation procedures:

(1) Graduates of accredited colleges of osteopathic medicine may provide musculoskeletal manipulations. Possession of the Doctor of Osteopathy (D.O.) degree implies adequate education and training for initial privileging.

(2) MTFs may privilege allopathic physicians, physician assistants, and physical therapists to perform musculoskeletal manipulations provided they can provide evidence of appropriate training or experience acceptable to the credentials committee. (Physician assistants and physical therapists will have a named physician supervisor who is similarly privileged.)

(3) Practitioners performing manipulative procedures will explain to the patient the nature and purpose of the procedure, its anticipated risks, benefits, and alternative treatments with their risks and benefits. This will be documented on SF 509 or SF 600, as appropriate.

(4) Only specifically privileged physicians (D.O. or Doctor of Medicine (M.D.)) may perform manipulation procedures of the lower back when using general anesthesia or intravenous medications. The general anesthesia will be administered by appropriately privileged anesthesiologists or anesthetists.

4–9. Suspension, restriction, or revocation of clinical privileges

a. Action processes. These actions are taken for health care activity incompetence or unprofessional conduct. Actions taken may be summary (immediate) or routine. QA investigations may be immediate (medical incident or significant unprofessional conduct) or routine (provider competence or professional behavior). In any case involving privileging action, the practitioner will be advised of his or her hearing rights (*e* below). No punishment or any form of retaliatory action will be taken against an informant providing information concerning a practitioner unless it is later determined that the information was false and the informant acted maliciously. Actions to withdraw clinical privileges will be taken promptly when there is reasonable cause to doubt the practitioner's competence to practice or for any other cause affecting patient safety. Reasonable cause includes—

(1) A single incident of gross negligence.

(2) A pattern of inappropriate prescribing.

(3) A pattern of substandard care.

(4) An act of incompetence or negligence causing death or serious bodily injury.

(5) Abuse of legal or illegal drugs or diagnosis of alcohol dependence. (See chap 7.)

(6) Practitioner disability (physical and psychiatric).

(7) Significant practitioner unprofessional conduct (*k*(5)below).

b. Summary action.

(1) *Steps involved.*

(a) Summary action will be taken for cause by the commander or the chairperson of the credentials committee of a MEDDAC, MEDCEN, or DENTAC. It immediately details the practitioners involved to nonclinical duties. (If necessary the commander may allow the practitioner to continue essential patient care under supervision, such as care of inpatients with whom only he or she is familiar.) Causes for this action are as follows:

1. A practitioner's conduct (or allegations thereof) that requires immediate action to protect the health or safety of patients, employees, or others in the MTF or DTF.

2. A practitioner's involvement in (or alleged involvement in) an incident of gross negligence or acts of incompetence or negligence causing death or serious bodily injury.

(b) If a patient's welfare is immediately threatened, the chief of the department or service in which the practitioner is assigned has the same authority as the commander or chairperson to take summary action. In unusual situations, for example, inebriation or bizarre behavior, the senior medical officer available, of whatever grade, will have authority to act summarily.

(c) The commander (or DCCS, if the commander is not readily available) will review the action at the first available opportunity. Such action (abeyance) will become effective immediately and will not exceed 14 days except that the commander may extend the action for an additional 14 days.

(2) *Immediate notification.* Immediate telephonic notification to the next higher headquarters and to SGPS–PSQ (AUTOVON

289–0088 or commercial (703) 756–0088) will be made of any incident of gross negligence and acts of incompetence or negligence causing death or serious bodily injury, or allegations thereof. Written confirmation of telephonic notification will be per *k* below.

(3) *QA investigation.*

(a) In cases of summary action (medical incident or significant unprofessional conduct) there will be an immediate investigation. The chairperson of the credentials committee will appoint an officer, pursuant to the authority of this regulation, to conduct an informal investigation and report to the credentials committee. The MTF commander may request that an officer with the appropriate specialty be made available from another command;that is, the regional Army MEDCEN for U.S. Army Health Services Command (HSC) MEDDACs and clinics, or Headquarters (HQ), HSC for HSC MEDCENs; HQ, 7th MEDCOM for MTFs in Europe; the 18th MEDCOM for Japan and outlying MTFs in Korea; and Tripler Army MEDCEN for the 121st EVAC hospital.) To maximize objectivity, a recognized, unaffiliated civilian specialist may be requested to actively participate in the investigation wherever practical.

(b) The investigation may include voluntary consultation with the practitioner; review of any relevant documents; or discussions with other persons having knowledge of the conduct involved. When the investigation is complete, the report should present factual findings of the investigation and may include conclusions or recommendations. The commander need not await the conclusion of the investigation prior to returning the practitioner to clinical duties. When early phases of the investigation clearly indicate the absence of substandard performance, the credentials committee should meet, review the preliminary details of the investigation and advise the commander without delay. At the conclusion of the investigation, the credentials committee will review the full report and make recommendations concerning the practitioner's clinical privileges. The practitioner will be notified of his or her hearing rights.

c. Routine action. When adverse information is submitted to the credentials committee and summary action is not necessary, the action to be taken may include—

(1) *Investigation.* If more information or background concerning the practitioner's conduct is necessary, the credentials committee chairperson may investigate further per *b*(3) above, or may designate an investigating officer to do so. In designating an investigating officer, it should be remembered that while such officer is usually available to testify at any hearing after the investigation, he or she is disqualified from participation in or voting as a member of the credentials committee on this matter.

(2) *Credentials committee chairperson action.* After reviewing the investigation report and/or other pertinent information, the chairperson may—

(a) Recommend that no action be taken.

(b) Initiate summary action.

(c) Determine that the information warrants review by a hearing committee for recommendations as to whether the practitioner's privileges should be suspended, restricted, or revoked.

(3) *Collateral actions.* In the case of suspected drug or alcohol involvement, a member of the impaired provider committee will be appointed to the hearing committee. (See chap 7.) If a hearing is required, the chairperson will give the practitioner written notice of it per *f* below. In the event the practitioner waives the hearing, the credentials committee will send its recommendations to the MTF commander. It will also deliver a copy of its recommendation to the practitioner. A notice of the commander's decision will be delivered to the practitioner with a copy placed in the PCF (para 4–11).

d. Suspension or restriction of clinical privileges. In any case involving actions other than total suspension of privileges, the commander will designate by name a supervisor or peer who will submit progress reports to the credentials committee at specified dates (internal determination) documenting current performance.

(1) Where the MTF commander has restricted a practitioner's privileges and he or she is no longer performing the full range of normal duties in his or her specialty practice, consideration will be given to separation in a less than fully privileged status (military) or taking actions for failure to maintain conditions of employment (civilian). If the practitioner remains on active duty, consideration will be given to changes in AOC or SI and specialty pays. The commander will make a recommendation through the major MEDCOM to the U.S. Total Army Personnel Command, (TAPC–OPH-appropriate career branch), 200 Stovall Street, Alexandria, VA 22332–0417, with an information copy to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(2) A suspension period will not ordinarily exceed 60 days and can only be extended by the commander for good cause; for example, investigation, completion of appeal, or illness of any necessary participant.

e. Hearing rights.

(1) As soon as practicable (but in no case later than 14 days) after action affecting a practitioner's privileges is taken, or after an investigation when the investigation provides reasonable cause, a written notice of the privileging action will be delivered to the practitioner personally or by certified mail, return receipt requested (fig 4–1). A separate page endorsement (receipt acknowledgment) will accompany the written notice (fig 4–2). The written notice of the privileging action will specify the deficiencies, suspension, restrictions, and duration, and the right to a hearing before a hearing committee.

(2) The practitioner will have 10 duty days to give written notice to the credentials committee chairperson requesting a hearing. Upon receipt of the request for a hearing, the hearing will be scheduled per *f* below. Failure to request a hearing or failure to appear at the hearing, absent good cause, constitutes waiver of a hearing and appeal rights. The commander will determine, if requested by the practitioner, whether good cause existed. This decision is final and not subject to appeal. In the event of a waiver, the committee's recommendation will be forwarded to the MTF commander for review and final action. The final action along with the notice of action will become a part of the PCF (para 4–11).

f. Hearing committee procedures.

(1) The senior member of the hearing committee will be designated as the chairperson. The hearing is administrative in nature. Therefore, the rules of evidence prescribed for trials by courts-martial or for court proceedings are not applicable. The committee must be fully informed of the facts so that it may make an intelligent, reasonable, good-faith judgment. To become informed, the committee may question witnesses and examine documents as necessary. The procedures in AR 15–6 should be consulted for procedural guidance in conducting the hearing; however, they are not binding on proceedings under this regulation.

(2) The chairperson of the hearing committee will advise the practitioner in writing (fig 4–3), delivered personally with a memorandum for acknowledgment (fig 4–4), or by certified mail, return receipt requested, of the following:

(a) The specific concerns that led to the need for the hearing(including dates and pertinent documents where appropriate).

(b) The time and location of the hearing (which will be 10 duty days from the receipt of the notification unless extended by the hearing committee chairperson for good cause). For RC practitioners, the hearing will be within 30 calendar days of the notification.

(c) The names of the witnesses to be called to testify to the hearing committee.

(d) The right to be present, to present evidence, to question witnesses called, and to call witnesses in his or her behalf. The practitioner should be advised that he or she is responsible for arranging the presence of his or her witnesses and failure of such witnesses to appear will not constitute a procedural error or basis for delay of the proceedings.

(e) The right to consult legal counsel. (See (3) below.)

(3) The practitioner is free to consult with legal counsel or any other representative. While such representatives may attend the hearing and advise the practitioner during the hearing, such representatives will not be allowed to participate directly in the hearing (for example, they will not be permitted to ask questions, respond to questions on behalf of the practitioner, or seek to enter material into the record).

(4) During an investigation or hearing under this regulation and if requested by the employee, the exclusive representative of an appropriate bargaining unit has the right to be present under the following conditions:

(a) Whenever a civilian employee of the unit is the subject, practitioner, or witness during the proceedings.

(b) If the employee reasonably believes that the inquiry could lead to disciplinary action against him or her. Unless required by the collective bargaining agreement, there is no requirement to advise the employee of this right. If the employee requests the presence of the exclusive representative, a reasonable amount of time will be allowed to obtain him or her. The servicing civilian personnel office and labor counselor will be consulted before denying such a request. The role of the union representative is not wholly passive, although he or she will not be permitted to make the proceedings adversarial. Subject to the direction of the hearing committee chairperson, the union representative may be permitted to explain the employee's position (if the employee agrees) or to persuade the employee to cooperate in the proceedings.

(5) The committee will review all the material presented, including that provided by the practitioner. If criminal misconduct, including dereliction of duty, is known or suspected, the chairperson of the hearing committee will advise the practitioner of his or her rights, using DA Form 3881 (Rights Warning Procedure/Waiver Certificate). The chairperson will arrange for the orderly presentation of information. If an investigating officer was designated per *c*(1) above, he or she may present exhibits and testimony to the hearing committee. The investigating officer will not participate in committee deliberations. Any objections made by the practitioner will be ruled on by the chairperson. A summarized record of the proceedings will be made, although in rare cases the chairperson may have the proceedings recorded in verbatim form, if approved by the MTF commander. (If a verbatim record is requested, the chairperson should ascertain from the servicing judge advocate office whether a Department of the Army (DA) court reporter (military or civilian) is available and provide this information to the commander. Funds may not be expended to hire a contract reporter.) Because these proceedings are covered by 10 USC 1102, no recording devices, other than that used by the reporter or secretary to prepare the record, will be permitted in the hearing.

(6) At the close of the presentation, the practitioner being examined will be excused, and the hearing committee will determine, by majority vote ((8) below), the recommendations to be made. They may include (but are not limited to)—

(a) Reinstating privileges.

(b) Setting terms of limitations such as requirements for consultation and identifying deficiencies that require improvement. (The committee should not make recommendations involving the reassignment of a practitioner.)

(c) Suspending or limiting clinical privileges and specifying the length of time. (The hearing committee should also recommend whether a practitioner should be released from active duty or employment (para 4–4*a*).)

(d) Revoking clinical privileges.

(e) Reconvening the hearing, after appropriate notice to the practitioner, to consider additional relevant evidence.

(7) The hearing committee should bear in mind the gravity of its responsibilities and the need to clearly document the basis for its findings and recommendations. General statements should be supported by specifically identified incidents or situations. Case histories relied on should be tabbed as exhibits to the record and documented by copies of pertinent medical records where feasible.

(8) Each member of the committee must either vote yes or no. No abstentions are permitted. Voting will be done by secret ballot.

(9) The members of the credentials committee may act as the hearing committee (*g* below). A member of the practitioner's discipline should also be a member of the hearing committee.

(10) The hearing will be closed to the public. However, the practitioner may request that observers be permitted. The chairperson will normally grant the request. The chairperson may limit the number of observers and exclude those who are disruptive.

(11) The hearing committee may obtain advice concerning legal questions from the servicing judge advocate office. The practitioner should be advised of legal questions and answers.

g. Action on hearing recommendations.

(1) After the record of the hearing has been prepared, the hearing committee will forward the record, including findings and recommendations, to the MTF commander. (See (2) below.) A copy of the findings and recommendations (and, if requested, a copy of the hearing record) will also be delivered to the practitioner. If all qualified members of the credentials committee did not act as the hearing committee, then the record, including findings and recommendations, should be forwarded by the hearing committee through the credentials committee to the commander. The qualified members of the full credentials committee (excluding any hearing committee members or member having acted as the investigation officer) must either concur by endorsement with the recommendations or may submit separate recommendations. If a member of the credentials committee is absent (for example, through TDY or illness) when the report is forwarded, such absence will be noted by the credentials committee chairperson, and the case forwarded to the commander without action by the absent member.

(2) Prior to action by the commander, the record, including findings and recommendations, will be reviewed by a judge advocate or DA civilian attorney for legal sufficiency. Where practicable, this review will not be conducted by the CJA.

(3) The commander will review the hearing record, including findings and recommendations. The findings and recommendations are advisory only and not binding on the commander. The commander will then make a decision regarding the practitioner's privileges. Written notice of the decision with the date of delivery noted on it will be delivered to the practitioner. A copy of the notice will be placed in the individual's PCF. The appropriate department, service, or clinic chiefs will also be advised of the decision. If the decision includes suspension, restriction, or revocation of privileges, the notice should advise the practitioner of the right of appeal. (See *e* above.) For a contract practitioner, there is no right of appeal beyond the MEDDAC, MEDCEN, or DENTAC level.

h. Separation.

(1) The loss of clinical privileges of an AMEDD practitioner may be the basis for separation from military or civilian service (see AR 635–100 and AR 135–175). When clinical privileges of an AMEDD military or civilian practitioner are suspended, restricted, or revoked, a local command review will be held to determine whether the practitioner should be considered for separation.

(a) For practitioners separating in a less than fully privileged status, information will be released to appropriate professional regulating authorities only by TSG. The practitioner will be informed of the effects of leaving the service in a less than fully privileged status.

(b) For a practitioner with a service obligation, consideration must then be given to branch transfer or reclassification action or, as an exception to policy, elimination from the service.

(2) The facility that initiated adverse privileging actions will be responsible for finalizing privileging actions. This includes actions when a practitioner has been sent to another facility for evaluation and found unfit for duty. In this case the practitioner must also be advised of his or her rights of due process.

i. Civilian training. If subsequent to an adverse privileging action the practitioner is not separated and seeks remedial training at a civilian institution, that institution will be notified of the adverse privileging action.

j. Off-duty employment. In the event of suspension or loss of clinical privileges by a military practitioner who has permission to engage in remunerative professional civilian employment at a hospital, medical center, or other institution providing health care services, action will ordinarily be taken to withdraw permission for continued employment per AR 40–1. Such civilian employer will be notified of all privileging actions by the MTF commander as they

occur, if the practitioner continues employment. This is the only exception to TSG as the information releasing authority.

k. Reporting requirements.

(1) *Clinical privileges changes.* When an MTF commander suspends, restricts, or revokes clinical privileges of a practitioner, the commander will complete DD Form 2499 (Health Care Provider Adverse Clinical Privileges Action Report (RCS DD–HA(AR)1611)). One copy will be submitted within 3 workdays following each adverse privileging action through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. For a supply of blank DD Forms 2499, see appendix A. For preparation of DD Form 2499, see *l* below.

(2) *QA investigations.*

(a) The beginning of an investigation will be reported within 2 workdays to the next higher headquarters.

(b) If an allegation is not substantiated, the commander will send a report within 7 workdays of the completion of the investigation through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. The report will provide the following:

1. A summary of the information giving rise to the investigation.

2. The rationale for the commander's decision.

3. A notation signifying level of confidence in the practitioner's performance.

(c) Status reports (status changes) using DD Form 2499 will be provided through the next higher headquarters to HQDA (SGPS–PSQ) until final action has been completed and so indicated on a DD Form 2499. This form should have the date mailed from the MTF in the top right corner.

(3) *Hearing decision.* Copies of the written notice of the commander's decision (*g* above) will be sent to the next higher headquarters along with DD Form 2499 upon completion of the privileging action if there was a restriction or revocation of privileges.

(4) *Restoration of privileges.* When the MTF commander approves total or partial restoration of clinical privileges previously removed, DD Form 2499 will be submitted per (1) above.

(5) *Reportable actions for unprofessional conduct.* Practitioners charged with any of the actions below will be evaluated by the credentials committee and privileging recommendations, if any, will be made to the commander. Although the credentials committee is not a criminal investigative body, it can and will consider all evidence from such investigations in its deliberations. Whenever any of the following occur, A DD Form 2499 will be submitted per (1) above. Any privileging actions will be noted. The commander will also notify any civilian facilities in which the practitioner is engaged in off-duty employment. An act is deemed to have "occurred" when the practitioner is indicted or titled for an offense (if applicable), or after completion of applicable proceedings and command action.

(a) Fraud or misrepresentation involving application for DOD service that results in discharge from the service.

(b) Fraud or misrepresentation involving renewal of contract for professional employment, application for or renewal of clinical privileges, or extension of service obligation.

(c) Cheating on a qualifying examination.

(d) Commission of a serious misdemeanor, defined as an action punishable by a fine or forfeiture of pay greater than $1000, confinement greater than 30 days, or punitive separation, whether under civilian or military jurisdiction.

(e) Entry of guilty, nolo contendere plea, or request for discharge in lieu of court-martial while charged with a serious misdemeanor or felony.

(f) Abrogating professional responsibility through any of the following actions:

1. Making false or misleading statements to patients regarding clinical skills and/or clinical privileges.

2. Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law.

3. Being found impaired by reason of drug or alcohol abuse or alcoholism.

4. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

(g) Commission of an act of sexual abuse, misconduct, or exploitation related to the practice of medicine or dentistry.

(h) Possessing, prescribing, selling, administering, giving, or using any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes.

(i) Prescribing, selling, administering, or providing a controlled substance for use by the practitioner or a family member of the practitioner without prior waiver of policy.

(j) Violating Federal, State, or military laws or regulations on controlled substances.

(k) Fraud under dual compensation provisions of Federal statutes relating to directly or indirectly receiving a fee, commission, rebate, or other compensation for the treatment of patients eligible for care in DOD MTFs.

(l) Failure to report to the privileging authority—

1. Any disciplinary action taken by professional or governmental organization reportable under this regulation.

2. Malpractice awards, judgments, or settlements occurring outside DOD facilities.

3. Any sanction taken by a civilian licensing agency or health care facility.

(6) *Charged practitioner separation.* A practitioner(military or civilian) will not be allowed to separate from DOD service until criminal investigations and resultant privileging actions are final unless the Secretary of the Army authorizes earlier separation.

(7) *Reporting authority.* TSG is the reporting authority to State regulatory authorities, the Federation of State Medical Boards, the National Practitioner Data Bank, and/or other appropriate central clearinghouses regarding adverse privileging actions, unprofessional conduct ((5) above), and any charges of which the practitioner is found guilty, pleads guilty, pleads nolo contendere, or requests discharge in lieu of court-martial.

(8) *Late charges.* Charges of substandard performance and misconduct that are filed up to 12 months following separation from DOD service will be investigated and reported per (1) above. Such practitioners will be notified of the charges and of their rights.

l. DD Form 2499, completion instructions. Check the appropriate box for each numbered item on initial or first-time actions. When updating an action, as a minimum, respond to items 1 through 7 and 10 through 14.

(1) *Item 1.* Enter the fiscal year and the date of the report.

(2) *Items 2 and 3.* Enter the Service filing the report. If the practitioner is on active duty at the time of the privileging action, indicate the Service; otherwise check civilian.

(3) *Items 4 and 5.* Indicate whether this is an initial report or an update of a previously filed report. The date requested is the date of the action being reported.

(4) *Item 6a.* Enter the name of the MTF.

(5) *Item 6b.* Enter the Health Affairs Defense Medical Information System (DMIS) code for the facility responsible for maintaining and reviewing the PCF of the practitioner. The DMIS number is available from AQCESS or the patient administration division of the MTF.

(6) *Item 7.* Enter the HCP's SSN.

(7) *Item 8.* Enter the profession of the practitioner. If the practitioner is a physician or a dentist, enter also the highest level of education (specialization) and the primary specialty.

(8) *Item 9.* Self-explanatory.

(9) *Item 10a.* This block requires a brief description of the type of action taken. Examples: Required to have consultation on all inpatients; operative surgery only with supervision, no emergency call, may not prescribe third generation cephalosporins, American Society of Anesthesiology Class I patients only.

(10) *Item 10b.* If the action is a suspension, enter duration. If permanent, also enter whether a restriction or a revocation.

(11) *Item 10c.* Enter all applicable actions.

(12) *Item 11.* Enter all applicable reasons for the adverse action. Circle the primary reason in cases involving more than one reason.

(13) *Item 12.* List the States in which the practitioner is known to be currently licensed.

(14) *Item 13.* Do not complete. Notification and completion of item 13 will be done by the Office of The Surgeon General.

4–10. Appeal process

a. Where the MTF commander has decided to suspend, restrict, or revoke clinical privileges, the practitioner will be granted 10 duty days (extendable in writing by the commander) to send a written appeal by certified mail to the next higher commander as follows:

(1) Continental United States (CONUS): Commander, Health Services Command (includes Alaska, Hawaii, and Panama).

(2) Outside continental United States (OCONUS):

(a) Commander, 7th MEDCOM—Europe.

(b) Commander, 18th MEDCOM—Korea and Japan.

b. The appropriate major MEDCOM commander in *a* above will establish a committee of at least three senior physicians (MC officers), one of whom will be of the same discipline as the practitioner being reviewed to act as the appeal committee. Other corps will each be represented when privileges in their respective disciplines are reviewed. If the practitioner is a dentist with no hospital privileges, the appropriate major medical commander may appoint a committee of three dental officers to act as the appeal committee. If the dentist has hospital privileges, the committee will consist of at least two physicians and one dental officer.

c. The appeal committee will review all information furnished by the practitioner, as well as the hearing record, findings, and recommendations. After considering the information, the committee will advise the major MEDCOM commander of the decision of the committee concerning the appeal, and the committee's recommendations as to the commander's action on the appeal. The findings and recommendations of the committee are advisory in nature, and do not bind the commander.

d. A copy of the decision on appeal will be forwarded by the major MEDCOM to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258, within 7 working days following the decision. This information should include a copy of the credentials committee minutes at which the original action was taken to modify privileges, a copy of the hearing proceedings and evidentiary material, and a copy of the decision on appeal.

e. The practitioner may appeal the decision of the major MEDCOM commander to the Office of The Surgeon General (HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258). This final written appeal must be sent by certified mail, return receipt requested, within 10 duty days after the practitioner receives notice of the MEDCOM commander's findings. If the practitioner appeals, TSG will be the final appellate authority for suspending, restricting, or revoking clinical privileges.

f. Administrative action to separate the practitioner as a result of a privileging action under paragraph 4–4 will normally be deferred pending appeal resolution. Practitioners who separate prior to resolution of their appeal will be informed in writing that the process will be completed as though they were still on active duty or employed. Special considerations such as extensions of time for appeal will not be granted.

g. For nonprivileged licensed practitioners, pending reporting to the National Practitioner Data Bank (para 4–13), appeal of notification to the data bank may be made to the MTF commander, who is the final authority.

4–11. Practitioner's credentials file

a. The PCF maintained for practitioners (para 4–1) will contain the documentation listed below. The PCF will be a six-part file (National Stock Number 7530–00–990–8884) with like documents grouped together and filed in reverse chronological order (most current on top).

(1) *Section I.*

(a) Identification photo (official military or passport photo).

(b) DA Form 4691–R.

(c) DA Form 5440–R-series (current and past).

(d) DA Form 5441–R-series (current and past).

(e) DA Form 4692–R (Clinical Privileges Annual Evaluation) (past).

(f) DA Form 5753–R (USAR/ARNG Application for Clinical Privileges to Perform Active/Inactive Duty Training) (for RC practitioners).

(2) *Section II.*

(a) DA Form 5374–R (current and past).

(b) Provider activity profile data as determined by the credentials committee and commander per paragraph 4–8*e*(3) (in summary form).

(c) Credentials and privileges granted (scope of practice) from civilian MTFs or DTFs where the member is employed or practicing (for RC practitioners).

(3) *Section III.* Documents of adverse action by Army MEDDAC, MEDCEN, or DENTAC:

(a) Letters of notification.

(b) Letters of acknowledgment.

(c) Hearing summary or minutes.

(d) Investigations.

(e) Adverse statements, to include National Practitioner Data Bank reports.

(f) Letters of decision.

(g) Malpractice claims together with the peer review determination whether the standard of care was met, and National Practitioner Data Bank reports.

(h) Copies of any other adverse information.

(4) *Section IV.*

(a) Medical continuing education (CE) summary, which includes a 3-year history of courses, sponsors, locations (city and State), dates (start/end), and CE hours/units (AQCESS summary). This education or training will be validated.

(b) Lectures given, papers published, and special activities (for example, research).

(5) *Section V.* DA Forms 5440–R-series, 5441–R-series, and 5374–R from previous MTFs or privileges granted at civilian agencies, if applicable.

(6) *Section VI.*

(a) Copies of diplomas, certification, licenses, and so forth.

(b) Verification documentation (para 4–6*c*).

b. The PCF will be released only to the MEDDAC, MEDCEN, or DENTAC commander; the credentials committee; and reviewing authorities or officially appointed auditors or inspectors. The practitioner may, however, authorize release to others; for example, drafting letters of recommendation. (See para 4–9*h* on separation.)

c. The PCF will be kept for the entire service career of the military practitioner to include active and inactive service in the ARNG or USAR. For civilians, it will be kept for the entire period of work within the AMEDD. For the active duty practitioner who joins the ARNG or USAR, the gaining RC unit will request the PCF from the last MEDDAC, MEDCEN, or DENTAC of appointment.

d. PCFs of personnel attending schools or changing duty stations will be forwarded per paragraph 4–3.

e. Disposition of PCFs is as follows:

(1) Copies of PCFs and PAFs of practitioners containing any permanent adverse privileging actions will be sent to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258, at the time of separation.

(2) Copies of PCFs of practitioners who have separated in good standing with defined privileges will be maintained by the MTF of last assignment or employment for at least 1 year.

(3) For disposition of the original PCF after a practitioner separates or retires from service or, if civilian, ends his or her employment with the AMEDD, see AR 25–400–2, FN 40–66d.

4–12. Practitioner activity file

a. A PAF will be maintained for each practitioner; it is a peer review working file. Material to be kept in the PAF will reflect the following in semiannual increments:

(1) *Practice profile, for practitioners with admission privileges.* AQCESS Practice Profile reports providing number of discharges, procedures (by procedure), deliveries, intensive care unit admissions, and inpatient deaths.

(2) *Practice profile, for primary care practitioners without admission privileges.* Average daily patient load, number of times assigned emergency services, percentage of time in deployed status, and name of supervising physician, as appropriate (AR 40–48).

(3) *Outcome.*

(a) Cases of superior care with appropriate documentation.

(b) Number of cases referred to the credentials committee regarding possible substandard care. (AQCESS Provider Profile reports showing variations;that is, surgical case, transfusion and drug usage reviews, and occurrence screens may be used.)

(4) *Malpractice.* RM data relating to filed or settled malpractice cases together with peer review findings. Claims reported to the risk manager identifying practitioner involvement will be posted to that practitioner's PCF, together with the peer review determination as to whether the standard of care was met.

(a) The chairperson of the RM committee, using military memorandum format, will forward to the credentials committee chairperson his or her statement that further assessment by the credentials committee is requested. Subsequent to credentials committee review and determination that the standard of care was or was not met, the original memorandum, together with committee findings or action, will be placed in section II of the PCF. The credentials committee will document the committee action in its minutes.

(b) It is expected that most malpractice claims will have been reviewed as PCEs or adverse events and, therefore, resolved by the RM program or referred to the credentials committee for its assessment. When this review has occurred and a claim arises after previously being reviewed as a PCE, the risk manager will forward a formal statement to the credentials committee indicating either that no further action is required or the claim requires further assessment.

(c) Claims identified by the MTF on practitioners who have departed on PCS or separation will be reviewed as above. Findings and committee minutes will be forwarded through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(d) Claims will be reviewed by the RM committee in an attempt to identify those practitioners who provided the patient care that formed the basis for the claim and, when identified, the above procedures will apply.

(5) *Administrative.*

(a) AQCESS Provider Profile reports providing expiration dates of basic cardiac life support (BCLS), advanced trauma life support (ATLS), and advanced cardiac life support (ACLS) training certificates.

(b) Reports on medical record deficiencies and delinquencies. At a minimum, the following medical record deficiencies will be identified and recorded:

1. History and physical not done within 24 hours of admission.

2. Operative report not dictated within 24 hours of completion of surgery.

3. Narrative summary not dictated within 4 working days of patient discharge.

(6) *Committee actions.* Ongoing peer review; that is, minutes, recommendations, counseling, and sanctioning documents of any case leading to investigation or adverse privileging actions of the practitioner.

(7) *Other.* The PAF will at all times contain a verified current State license expiration date, date of last clinical privileges reappraisal (minimum of every 2 years), date of last training (certification of completed courses, and number of hours or units of continuing education certified by professional societies or associations).

b. The PAF will be filed with the PCF but will not be part of the PCF.

c. The chief of the department or service will use the PAF data in periodic reevaluation and privilege reappraisal (para 4–8*e*).

d. The PAF data may be removed and destroyed, except as required to be transferred to the PCF (para 4–11), when the credentials committee judges that the data are reflected accurately and completely in the most current performance assessment and privileges reappraisal. (The practitioner should be given the opportunity to keep any productivity and computer-generated data prior to its destruction.)

e. A practitioner may, on request and in the presence of a command representative, be allowed to review the contents of his or her PAF. In addition, the contents of the PAF may be used by an appropriate supervisor for counseling purposes, letters of recommendation, letters of inquiry, evaluation reports (for example, OER), and preparation of graduate professional education documentation and reference.

f. PAF criteria definitions are in the glossary.

4–13. National Practitioner Data Bank reports

a. Public Law 99–660. (The Health Care Quality Improvement) Act of 1986, Public Law 99–660, title IV provides for reporting of malpractice claims resulting in monetary settlements and professional review actions to the National Practitioner Data Bank. HCPs (para 9–1) will be reported, whether licensed or under grace periods or waivers for licenses. 10 USC 1102 provides protection for those providing information to professional review bodies, unless such information is false and the persons providing it knew that the information was false.

b. Malpractice payments. Upon notification by the local CJA to the risk manager that a monetary award has been granted to a claimant (settled administratively by the Army Judge Advocate General Corps or litigation cases settled or adjudicated by the Department of Justice), the MEDDAC, MEDCEN, or DENTAC will report the following within 7 working days per *e* below.

(1) Name of claimant.

(2) Name of patient (if not the claimant).

(3) Claim number used by the CJA.

(4) MTF or DTF.

(5) Date of incident.

(6) Primary and secondary diagnoses for which the patient entered care. (See narrative summary in inpatient treatment record (ITR) for inpatients.)

(7) Amount and date of settlement or adjudication.

(8) Name, rank, SSN, and AOC or SI of practitioner with primary care responsibility (excludes house staff).

(9) Nature and attribution of alleged negligence or incompetence that led to the claim. The attribution may include one or more of the following:

(a) A physician.

(b) A nonphysician.

(c) Institutional responsibility; for example, equipment and power failure. (Payment for claims that deviate from standards of care but outside the control of practitioner will not be reported to the data bank.)

(10) Peer review of performance of the practitioner to whom the care was attributed and how, in the opinion of the review body, the situation might have been avoided. This body will then categorize the case as—

(a) Met standards of care.

(b) Minor deviations from standards of care.

(c) Did not meet standards of care (major deviations).

(11) When peer review determines substandard care to one or more licensed practitioners (excludes house staff), a separate report will be submitted for each practitioner.

c. Professional review actions.

(1) Professional review actions are privileging actions that adversely affect clinical privileges for privileged practitioners (after appellate review, commander decision if no appeal, or separation—whichever comes first).

(2) For HCPs (para 9–1), whether licensed or under grace periods or waivers, and house staff who are convicted, plead guilty, plead

nolo contendere, receive a discharge in lieu of court-martial, receive a discharge in lieu of criminal investigation, or receive a less than honorable discharge for unprofessional conduct (para 4–9*k*(5)), a DD Form 2499 will be submitted within 3 working days of the date the practitioner was formally charged with committing the unprofessional conduct or on the date of discharge, whichever comes first.

(3) For HCPs not individually privileged, DD Form 2499 will be completed as follows:

(a) Blocks 1–9, information as appropriate.

(b) Block 10, omit.

(c) Block 11, check or specify the reason for action.

(d) Block 12, give State of licensure and expiration date.

(e) Block 13, do not complete. TSG is the notification authority.

d. PCF. Copies of the reports sent for inclusion in the data bank will be placed in Part III of those practitioners' PCF identified with the case. If the practitioner(s) is no longer at the MTF or DTF, the report will be sent to HQDA (SGPS–PSQ). (See *e* below.) (For the nonprivileged HCP, a notation will be made in the appropriate departmental or service records.)

e. National Practitioner Data Bank reporting. Reports will be sent through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. TSG is the reporting authority. Copies of reports sent will be given to the HCPs.

f. HCP Data Bank inquiries. Inquiries for data on HCPs will be made to the National Practitioner Data Bank as follows:

(1) By the appropriate recruiting agency at the time of application for employment.

(2) By the MEDDAC, MEDCEN, or DENTAC at the time a practitioner applies for clinical privileges.

(3) By the MEDDAC, MEDCEN, or DENTAC at the time of periodic reevaluation and privilege renewal.

(4) By the MEDDAC, MEDCEN, or DENTAC at the beginning of any investigation of an HCP for substandard performance or unprofessional behavior.

4–14. Retired mobilization volunteers

a. Preassigned retired volunteers meeting requirements for clinical privileging (para 4–1) will forward a copy of their PCF at the last MEDDAC, MEDCEN, or DENTAC of assignment to the credentials committee of the preassigned MEDDAC, MEDCEN, or DENTAC.

b. The MEDDAC, MEDCEN or DENTAC staff operations officer or equivalent will semiannually give the credentials committee a current list of preassigned retired volunteers. If a needed PCF is not available, the facility will send a letter to the volunteer requesting a copy of the PCF. This PCF should be filed in the retired volunteer's Military Personnel Records Jacket (MPRJ) on file at U.S. Army Reserve Components Personnel and Administration, ATTN: DARC–PPC, 9700 Page Boulevard, St. Louis, MO 63132–5200. In the event that the volunteer is unable to obtain a copy of the PCF, DA Form 4691–R (front side only) will be submitted.

c. If the volunteer has not responded by the next semiannual update, the operations officer will be informed that the individual's credentials must be made available and verified in order to continue participation in the program.

(MEDDAC, MEDCEN, or DENTAC Letterhead)

S: ***(Suspense date)***

OFFICE SYMBOL (640–10e) ***(Date)***
MEMORANDUM FOR ***(Name, Grade, and Address of Practitioner)***

SUBJECT: Notice of Summary of ***(Limitation) (Suspension)*** of Clinical Privileges

1. You are hereby notified that your clinical privileges at ***(MEDDAC, MEDCEN, or DENTAC)*** are ***(limited) (suspended)*** as follows: Effective immediately your clinical privileges have been ***(limited) (suspended)*** for improper (state specifically the deficiencies involved and the scope of the action). The period of ***(limitation) (suspension)*** is ***(indefinite) (temporary)*** pending action by the credentials committee at its meeting scheduled for ***(date)***.

2. You are advised that you have the right, upon your request, to have the credentials hearing committee conduct a hearing to review this action concerning your privileges. The hearing procedures and your hearing rights are detailed in AR 40–68, chapter 4.

3. In order to have this hearing, you must make a written request for the hearing to the chairperson of the credentials committee within 10 days from the date you receive this notice. If you fall to make the request within that time or if you fail to appear at the hearing so requested, you waive your rights to the hearing and also waive rights to appeal to higher medical or dental authority.

FOR THE COMMANDER (if authorized):

(Signature)

(Typed name)
(Grade and corps)
Chairperson, Credentials
Committee

Figure 4-1. Sample format for a memorandum of notification for a summary action

S: ***(Suspense date)***

PRACTITIONER"S OFFICE SYMBOL ***(Basic Memo Office Symbol/(Date))*** (640–10e)

1st End Practitioner/typist initials/telephone no.

SUBJECT: Notice of Summary of ***(Limitation) (Suspension)*** of Clinical Privileges

(Name, Grade, and Address of Practitioner) (date)

FOR: ***(COMMANDER, MEDDAC, MEDCEN, OR DENTAC AND ADDRESS,***
ATTN: Chairperson, Credentials Committee)

Receipt acknowledged. I understand that I have 10 days to request a hearing, if I elect to do so, in accordance with AR 40–68. Further I understand that should I elect not to request a hearing or if I fail to appear at a hearing, I waive my right to appeal to higher medical or dental authority.

(Signature of practitioner)

(Typed name)
(Grade, and corps)

Figure 4-2. Samplee format for a separate page endorsement to a memorandum of notification for a summary action

(MEDDAC, MEDCEN, or DENTAC Letterhead)

S: ***(Suspense date)***

OFFICE SYMBOL (640–10e) ***(Date)***
MEMORANDUM FOR: ***(Name, Grade, and Address of Practitioner)***

SUBJECT: Notification of credentials hearing

1. (The credentials committee) (a credentials hearing committee) will conduct a hearing concerning allegations that may adversely affect your clinical privileges.

2. The allegations to be reviewed are (state the nature of the allegations constituting the grounds for the hearing in sufficient detail. Include the date, identity, and location of the records of activities or cases that are involved in the allegations, so that the practitioner will be appraised of the matters under investigation.)

3. The committee will hold the hearing at ***(hour)*** on ***(date)*** at ***(location).*** You have the right to be present, to present evidence and call witnesses in your behalf, to cross-examine witnesses called by the committee, to consult legal counsel, and to be advised by legal counsel at the hearing. It will be your responsibility to arrange for the presence of any witnesses you desire. Military counsel will not be made available to advise you at the hearing. You may retain a civilian attorney at your own expense.

a. Failure to appear at the hearing will constitute a waiver of the rights listed here and the right to appeal.

b. The time and place of the hearing may be changed by the chairperson of the hearing committee upon your written request before the indicated suspense date if based on good cause.

c. The committee will call the following witnesses: (list of witnesses, if any.)

FOR THE COMMANDER (if authorized):

(Signature)

(Typed name)
(Grade, and corps)
Chairperson, Credentials
Committee

Figure 4-3. Sample format for a memorandum of notification for a credentials hearing

(MEDDAC, MEDCEN, or DENTAC Letterhead)

OFFICE SYMBOL (640–10e) ***(Date)***
MEMORANDUM FOR ***(MEDDAC, MEDCEN, or DENTAC and Address,***
ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of a Memorandum of Notification of a Credentials Hearing

I hereby acknowledge receipt of the subject Memorandum of Notification of a Credentials Hearing. The memorandum is dated ***(date)*** and I received it on ***(date).***

(Signature of practitioner)

(Typed name)
(Grade, and corps)

Figure 4-4. Sample format for a memorandum for acknowledgement of receipt of a memorandum of notification for a credentials hearing

Chapter 5
Dental Activity

5–1. Policy

a. The DENTAC commander will provide quality patient care through continued assessment of the quality and appropriateness of patient care. The DENTAC commander is responsible for all aspects of QA for all personnel who practice within his or her dental treatment facility (DTF).

b. The DENTAC commander will publish a written QAP addressing the following essential components of QA:

(1) Patient care evaluation.

(2) Initial credentialing, granting of clinical privileges, licensure, certification, and other professional qualifications.

(3) Utilization management.

(4) RM.

c. The DENTAC QAP will parallel the MEDDAC or MEDCEN QAP (chap 3), the exceptions being provided in this chapter.

d. QA is a decentralized function with each DTF responsible to assess its operation, conduct problem solving and reassessment, and report unresolved problems to the DENTAC QA committee for action. QA will be a priority for the Command Inspection Program.

5–2. Dental activity quality assurance program committees

The structure of QAP committee organization will depend on the size and mission of the DENTAC. Each DENTAC or detachment with a Dental Corps (DC) officer commanding will have a QAP. Detachment QAP and organization will interface with the DENTAC exercising overall command. As a minimum, the following committees will be formed:

a. DENTAC QA committee. The QA committee is responsible for the execution of the DENTAC QA plan and will act as a resource to the professional staff on QA issues. Input to this committee will be provided by the activities listed in table 5–1.

(1) This committee will—

(a) Develop a written QA plan.

(b) Identify resources to implement an effective QAP.

(c) Review all patient care evaluation, utilization management, and RM activities to include followup carried out at the DTF as necessary.

(d) Set priorities for problem solving.

(e) Have the authority to recommend corrective action.

(f) Notify the DENTAC commander when corrective action is recommended.

(g) Follow up to ensure that corrective actions are implemented.

(h) Integrate and coordinate QA findings, recommendations, and actions. When problems or opportunities to improve patient care involve more than one DTF, the committee will communicate information between DTFs.

(i) Report pertinent findings to the DENTAC credentials committee.

(j) Determine the overall effectiveness of the QAP at least annually.

(k) Provide minutes summarizing activities to the DENTAC commander.

(2) The exact composition of the committee will be determined by the DENTAC commander. However, DTF officers-in-charge, the executive officer (when assigned), the director of dental education (when not the DENTAC commander), and the senior NCO will be included. A dental officer will serve as chairperson.

b. DENTAC credentials committee. The role of this committee is to recommend to the commander the clinical privileges of DENTAC practitioners serving in the DENTAC. This also includes ARNG and USAR members serving in the DENTAC. The committee chairperson will keep and control the reports of the committee and the PCFs (para 4–11). Reports and recommendations of this committee will be sent directly to the DENTAC commander for approval or disapproval. Committee recommendations relating to the DENTAC commander will be sent directly to the senior dental officer in the major MEDCOM.

(1) The voting members of the credentials committee will be dentists.Committee membership will be determined by the DENTAC commander. The senior dental officer assigned to the committee will normally serve as chairperson.The commander will appoint a recorder as a nonvoting member. The chairperson may request a legal adviser (nonvoting) be present. When individual committee members, including the chairperson, are being evaluated for granting or restricting of privileges, they will not participate during that period when their PCF is being evaluated.

(2) The frequency and dates of meetings will be determined by the DENTAC commander and by committee workloads. (Meetings will be held at least once annually.) The committee will allow ample time to ensure a thorough appraisal of the practitioner and prevent expiration of privileges.Announcement of these sessions will be in writing 5 working days before the planned date. This announcement alerts those practitioners who will be evaluated to make their updated credentials and the privileges requested available to the committee before the meeting. An on-call session may be scheduled by the chairperson—

(a) To evaluate requests for additional privileges.

(b) To evaluate the credentials of new practitioners.

(c) To reevaluate practitioners who are in probationary or restrictive categories of professional activity.

(d) To consider or make recommendations to the DENTAC commander that a practitioner's privileges be suspended, restricted, or revoked, or that the practitioner be separated from active duty or employment.

(e) When directed by the DENTAC commander.

(3) The committee will not take action concerning a practitioner unless a quorum of members eligible to vote is present. A working quorum is defined as greater than 50 percent of the voting membership. Voting will be by secret ballot. All members of the committee must either vote yes or no. No abstentions are permitted. The total vote cast yes or no in a particular case will be recorded in the committee minutes.

(4) The credentials committee may evaluate the quality of care provided by any HCP, as requested by the DENTAC commander.

c. TAB. A DENTAC representative will serve on the MEDDAC or MEDCEN TAB (AR 40–2).

d. Infection control officer. A DENTAC representative will serve on the MEDDAC or MEDCEN infection control committee. This officer should be a member of the DENTAC QA committee. Infections control guidance of Army policy, the American Dental Association (ADA), the Centers for Disease Control(CDC), and the Occupational Safety and Health Administration (OSHA) will be followed.

5–3. Committee activities and reports

Committee activities and reports will follow the guidance provided in chapter 2.

a. Patient care evaluation (para 3–3).

(1) The monitoring and evaluation process is described in paragraph 3–2. The calendar of dental review topics appears in table 5–1.

Table 5–1
Calendar of dental review topics

Unit: Ancillary utilization **Submit:** Jan, Apr, Jul, Oct.
Unit: Dental clinic operations **Submit:** Monthly.
Unit: Dental laboratory service **Submit:** Mar, Jun, Sep, Dec.

Table 5–1
Calendar of dental review topics—Continued

Unit: Dental records and daily worksheet audit **Submit:** Monthly.
Unit: Drug and/or antibiotic usage **Submit:** Jan, Apr, Jul, Oct.
Unit: Patient satisfaction survey **Submit:** Mar, Sep.
Unit: Radiology QA **Submit:** Monthly.
Unit: Safety **Submit:** Mar, Sep.
Unit: Sterilization/infection control **Submit:** Monthly.
Unit: Utilization management **Submit:** Feb, May, Aug, Nov.

(2) Items in paragraph 3–3*a*(2), (3), and (5); and 3–3*b, c, d, e,* and *f* do not normally apply to a DENTAC.

(3) Dental record and worksheet audits form a major data source for the QAP. Each DENTAC will develop specific administrative guidance on conduct of the record or worksheet audit.

(a) Accuracy, timeliness, completeness, clinical pertinence, and medicolegal sufficiency will all be evaluated.

(b) Audits on each practitioner for each clinic of the DENTAC will be conducted monthly with results reported to the DENTAC QA committee.

(4) Drug use review including antibiotic use will be conducted. The reviews will focus on—

(a) Appropriateness of the drug therapy selected.

(b) Proper documentation of the prescribed drug in the dental record (SF 603 (Health Record—Dental) or SF 603A (Health Record—Dental Continuation)).

(c) Adherence to prescribing guidance such as the American Heart Association protocol for subacute bacterial endocarditis prophylaxis.

(5) Reviews of ancillary services include such items as utilization of preventive dentistry specialists, dental hygienists, and dental assistants(expanded function); adequacy of dental laboratory support; and the Dental Radiology QAP (as required by TB MED 521).

(6) Patient care evaluation reviews will establish criteria to be evaluated and standards that will measure the success of care delivery.

b. Utilization management (para 3–4). The DENTAC QA committee will, at least quarterly, review the management of resources available to the activity. The review will be documented in the committee minutes and will include—

(1) Time management in appointment scheduling and management of failed appointments.

(2) Management of examination and sick call hours and patient waiting time.

(3) Use of multiple treatment rooms by each care provider.

(4) Equipment and facilities management.

(5) Logistics management (program budget advisory committee (PBAC), medical care support equipment (MEDCASE), and Capital Expense Equipment Program (CEEP)).

c. DENTAC risk management. The DENTAC will follow the guidance contained in paragraph 3–5, as appropriate. The DENTAC will appoint in writing a risk manager for the activity. Duties of the risk manager (para 3–5*e*) will be performed by the appointed DENTAC risk manager. Risk management will normally be considered as part of the DENTAC QA committee and will not be a separate committee.

d. Occurrence screening.

(1) The DENTAC QA committee will develop a list of screening indicators which, when they occur, will trigger a review of adequacy of care. Such items as cardiac arrest, severe post-operative infection, return for the same complaint within 72 hours, and nerve or vessel damage during surgery will be included.

(2) Dental record and worksheet audits, dental officer of the day and charge of quarters logs, and voiced patient complaints are all sources for screening reviews.

(3) Occurrence screening should be an agenda item for each QA meeting, and findings, if any, should be documented in its minutes.

(4) Substantiated occurrences will be reported to the credentials committee. Developing trends should be carefully monitored.

e. DENTAC QAC. The DENTAC executive officer (where assigned), or civilian administrative assistant, will perform the duties outlined in paragraph 3–6.

5–4. Dental treatment facility quality assurance

DTFs will perform at least the following:

a. Review patient care evaluation, utilization management, and RM activities within the DTF. Findings will be reported to the DENTAC QA committee.

b. Identify problems, recommend corrective actions, and set problem solving priorities for the DTF.

c. Report actions taken and refer unresolved problems to the DENTAC QA committee.

5–5. Credentials review, privileging, and proceedings

a. Policies and procedures. Policies and procedures outlined in chapter 4, with the exception of the PAF, will apply to the DENTAC.

b. Privileging. Only those individuals given the authority and responsibility for independent decisions on initiating or altering a course of treatment will be privileged. Persons filling a standard job description or scope of practice (for example, preventive dentistry specialist, dental hygienist, dental assistant (expanded function)) and performing only under supervision will have their job performance monitored continually and formally evaluated annually. Such evaluation will normally be part of the Performance Appraisal and should be reported to the QA committee if deficiencies are noted.

c. Dental residents. Dental residents will function under the direction and supervision of a mentor. Residents who will provide emergency or after duty hours dental care in an unsupervised mode will be privileged to perform this care. TCFs (para 4–8*h*(2)) will be maintained by the DENTAC credentials committee. Clinical privileges felt warranted at the resident's first assignment will be recommended by the education committee and authenticated (signed) by the director of the dental training program. The recommended privileges will be based on performance during training.

d. DENTAC commander. After recommendation for approval of clinical privileges by the local DENTAC credentials committee, the entire PCF of the DENTAC commander will be sent by certified mail, return receipt requested, to the major MEDCOM approval authority for action.

(1) The comment/recommendation block of each privileges form for the DENTAC commander will contain the statement "Privileges and performance have been reviewed by the entire DENTAC credentials committee."

(2) After privileging actions have been documented, the signed forms will be returned by the approval authority for inclusion in the DENTAC commander's PCF maintained at the DENTAC.

e. Reporting requirements.

(1) Reporting requirements per paragraph 4–9*k;* that is, clinical privileges changes, QA investigations, hearing decisions, restoration of privileges, reportable actions for unprofessional conduct, and National Practitioner Data Bank reports will be reported through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(2) Immediate telephonic notification of any incident of gross negligence and acts of incompetence or negligence causing serious injury or allegations thereof will be made through the next higher

headquarters to HQDA (DASG–DC) (AUTOVON 289–0031; commercial (703) 756–0031). Written confirmation of the telephonic notification will be made per (1) above.

5–6. Delineation of dental clinical privileges

a. Privileges will be determined by education, training, and experience. Procedure code numbers and definitions from DA Pam 40–16 will be used so there can be no question as to the scope of privileges in each specialty area. Practitioners will be privileged before providing patient care. Practitioners who have successfully graduated from a dental school program accredited by the Council on Dental Education of the ADA may be privileged in general dentistry (AOC 63A). Practitioners who have graduated from a dental specialty residency program accredited by the ADA may be privileged to practice the scope of the specialty in which training was received. The dental procedures for which they are privileged are derived from the ADA code on dental procedures and nomenclature (modified) and DA Pam 40–16 as listed by AOC in tables 5–1 through 5–9.

b. A practitioner may request to be privileged in any procedures he or she is qualified to perform by submitting procedure codes on the applicable form and supporting documentation (if required) to the credentials committee for their evaluation and recommendation. The DENTAC commander is the final approving authority. Except for oral maxillofacial surgeons (AOC 63N), periodontists (AOC 63D), and pediatric dentists (AOC 63K), a certificate of training in an approved course is required for credentials in inhalation sedation, IV sedation, and general anesthesia.

c. The following is a list of DOD clinical procedure codes applicable to the scope of general dentistry and dental specialty areas; the list may be expanded or reduced by the local credentials committee to match the skill level of individual practitioners. Preventive dentistry specialists, dental assistants (expanded function), and dental hygienists are also listed. These specialists provide patient care under the direction and supervision of a dental officer.

(1) *General dentistry (AOC 63A).* The procedures listed in table 5–2 make up the general dentistry (AOC 63A) defined privileges category.(See para 4–2*a*(5).)

Table 5–2
AOC 63A Procedures

Code: 0120 **Procedure:** Periodic oral examination.
Code: 0125 **Procedure:** Identification charting.
Code: 0130 **Procedure:** Other examination.
Code: 0133 **Procedure:** Screening examination.
Code: 0140 **Procedure:** Comprehensive examination.
Code: 0150 **Procedure:** Written consultation.
Code: 0160 **Procedure:** Blood pressure recording.
Code: 0210 **Procedure:** Intraoral series.
Code: 0220 **Procedure:** Intraoral film.
Code: 0221 **Procedure:** Duplication of radiographs (other than panoramic).
Code: 0250 **Procedure:** Extraoral film.

Table 5–2
AOC 63A Procedures—Continued

Code: 0330 **Procedure:** Panoramic film.
Code: 0331 **Procedure:** Double panoramic film.
Code: 0332 **Procedure:** Duplication of panoramic radiographs.
Code: 0340 **Procedure:** Cephalometric film.
Code: 0350 **Procedure:** Diagnostic clinical photograph.
Code: 0360 **Procedure:** Identification photograph.
Code: 0410 **Procedure:** Bacteriologic cultures.
Code: 0460 **Procedure:** Endodontic diagnostic test.
Code: 1110 **Procedure:** Adult prophylaxis.
Code: 1120 **Procedure:** Child prophylaxis.
Code: 1240 **Procedure:** Topical fluoride, professional application.
Code: 1245 **Procedure:** Topical fluoride, self-applied, group.
Code: 1310 **Procedure:** Dietary planning.
Code: 1330 **Procedure:** Individual oral health counseling.
Code: 1331 **Procedure:** Group oral health counseling.
Code: 1350 **Procedure:** Application of pit and fissure sealants.
Code: 1360 **Procedure:** Plaque and tissue indices.
Code: 2140 **Procedure:** Amalgam, one surface.
Code: 2150 **Procedure:** Amalgam, two surfaces.
Code: 2160 **Procedure:** Amalgam, three surfaces.
Code: 2161 **Procedure:** Amalgam, four or more surfaces.
Code: 2205 **Procedure:** Glass ionomer without cavity preparation.
Code: 2215 **Procedure:** Glass inonomer with cavity preparation.
Code: 2320 **Procedure:** Resin, simple.
Code: 2336 **Procedure:** Resin, complex.
Code: 2340 **Procedure:** Acid etch.
Code: 2341 **Procedure:** Glazing composite.
Code: 2342 **Procedure:** Resin, esthetic.

Table 5–2
AOC 63A Procedures—Continued

Code: 2410
Procedure: Gold foil, Class I.

Code: 2430
Procedure: Gold foil, Class III.

Code: 2450
Procedure: Gold foil, Class V.

Code: 2460
Procedure: Gold foil, Class VI.

Code: 2511
Procedure: Inlay, one surface.

Code: 2521
Procedure: Inlay, two surfaces.

Code: 2531
Procedure: Inlay, three surfaces.

Code: 2541
Procedure: Onlay (cusp coverage).

Code: 2910
Procedure: Recement inlay, crown, or fixed partial denture.

Code: 2940
Procedure: Sedative/temporary restoration.

Code: 2952
Procedure: Restoration polish.

Code: 2953
Procedure: Pin retention.

Code: 2954
Procedure: Intermediate base.

Code: 2955
Procedure: Post retention.

Code: 2960
Procedure: Rubber dam application.

Code: 2970
Procedure: Enameloplasty or odontoplasty.

Code: 3110
Procedure: Direct pulp cap.

Code: 3120
Procedure: Indirect pulp cap.

Code: 3210
Procedure: Pulpotomy.

Code: 3230
Procedure: Pulpectomy, total.

Code: 3231
Procedure: Pulpectomy, partial.

Code: 3311
Procedure: Anterior root canal therapy, one canal.

Code: 3312
Procedure: Anterior root canal therapy, two or more canals.

Code: 3321
Procedure: Premolar root canal therapy, one canal.

Code: 3322
Procedure: Premolar root canal therapy, two canals.

Code: 3360
Procedure: Endodontic interim treatment.

Code: 4220
Procedure: Gingival curretage.

Code: 4321
Procedure: Provisional splint, extracoronal.

Table 5–2
AOC 63A Procedures—Continued

Code: 4322
Procedure: Removal of provisional splint, extracoronal.

Code: 4330
Procedure: Occlusal adjustment, limited.

Code: 4342
Procedure: Periodontal scaling.

Code: 4343
Procedure: Periodontal scaling and root planing.

Code: 4351
Procedure: Root desensitization.

Code: 5110
Procedure: Complete denture.

Code: 5130
Procedure: Immediate complete denture.

Code: 5201
Procedure: Partial denture, resin.

Code: 5203
Procedure: Partial denture, cast metal.

Code: 5205
Procedure: Immediate partial denture, cast metal.

Code: 5330
Procedure: Partial denture, corrected cast.

Code: 5611
Procedure: Complete denture repair.

Code: 5621
Procedure: Partial denture repair.

Code: 5711
Procedure: Duplicate denture.

Code: 5731
Procedure: Denture reline, chairside.

Code: 5751
Procedure: Denture reline, laboratory.

Code: 5763
Procedure: Complete denture rebase.

Code: 5765
Procedure: Removable partial denture rebase.

Code: 5820
Procedure: Remount, chairside.

Code: 5871
Procedure: Metal base.

Code: 5873
Procedure: Amalgam occlusals.

Code: 6110
Procedure: Crown/retainer, resin veneer.

Code: 6120
Procedure: Crown/retainer, porcelain.

Code: 6130
Procedure: Crown/retainer porcelain fused to metal.

Code: 6150
Procedure: Crown/retainer, partial veneer, metal.

Code: 6160
Procedure: Crown/retainer, metal.

Code: 6201
Procedure: Pontic, cast metal.

Code: 6203
Procedure: Pontic, porcelain.

Table 5–2
AOC 63A Procedures—Continued

Code: 6204 **Procedure:** Pontic, resin, veneered.
Code: 6220 **Procedure:** Pontic, slotted facing.
Code: 6240 **Procedure:** Pontic, porcelain fused to metal.
Code: 6610 **Procedure:** Replace broken facing.
Code: 6611 **Procedure:** Stain and glaze.
Code: 6612 **Procedure:** Broken connector.
Code: 6710 **Procedure:** Crown, resin processed.
Code: 6711 **Procedure:** Crown, resin interim.
Code: 6714 **Procedure:** Fixed partial denture, interim.
Code: 6719 **Procedure:** Crown, stainless steel, aluminum, tin.
Code: 6720 **Procedure:** Post-core, metal.
Code: 6730 **Procedure:** Composite resin fixed partial denture.
Code: 7110 **Procedure:** Tooth removal.
Code: 7120 **Procedure:** Tooth removal, complicated.
Code: 7140 **Procedure:** Tooth implantation, replantation, transplantation.
Code: 7210 **Procedure:** Repair traumatic wounds simple (up to 5 cm).
Code: 7310 **Procedure:** Aveoloplasty with extractions.
Code: 7412 **Procedure:** Excision, soft tissue.
Code: 7432 **Procedure:** Excision, benign tumor.
Code: 7481 **Procedure:** Sequestrectomy.
Code: 7511 **Procedure:** Incision and drainage.
Code: 7520 **Procedure:** Biopsy.
Code: 7530 **Procedure:** Removal of foreign body.
Code: 7570 **Procedure:** Cricothyrotomy.
Code: 7815 **Procedure:** Myofacial pain dysfunction treatment.
Code: 7835 **Procedure:** Mandibular manipulation.
Code: 7902 **Procedure:** Osteitis treatment.
Code: 7903 **Procedure:** Pericoronitis treatment.

Table 5–2
AOC 63A Procedures—Continued

Code: 8110 **Procedure:** Space maintainer removal.
Code: 8120 **Procedure:** Space maintainer, simple, fixed.
Code: 8210 **Procedure:** Habit breaker, removable.
Code: 8310 **Procedure:** Simple Hawley Device.
Code: 8330 **Procedure:** Bite plane, anterior, posterior.
Code: 8530 **Procedure:** Band and bonded attachment removal.
Code: 9211 **Procedure:** Local anesthesia.
Code: 9234 **Procedure:** Oral sedation or analgesia.
Code: 9630 **Procedure:** Other therapeutic medication.
Code: 9631 **Procedure:** Prescription.
Code: 9918 **Procedure:** Postoperative treatment.
Code: 9923 **Procedure:** Impression for dental cast.
Code: 9924 **Procedure:** Jaw relation records.
Code: 9926 **Procedure:** Laboratory procedures, adjunctive medical.
Code: 9940 **Procedure:** Mouth protectors/flouride carriers.
Code: 9972 **Procedure:** Patient handling time, diagnostic and preventive.
Code: 9973 **Procedure:** Patient handling time, all other clinical services.
Code: 9974 **Procedure:** Patient handling time, high risk, (infectious).

(2) *Comprehensive dentistry (AOC 63B).* Comprehensive dentists (AOC 63B) with defined privileges (para 4–2*a*(5)) and graduates of a 2-year residency program may perform all procedures listed in table 5–2 and table 5–3.

Table 5–3
AOC 63B Procedures

Code: 2343 **Procedure:** Laminate veneer facing.
Code: 2420 **Procedure:** Gold foil, Class II.
Code: 2440 **Procedure:** Gold foil, Class IV.
Code: 2542 **Procedure:** Pinledge restoration.
Code: 3323 **Procedure:** Premolar root canal therapy, three or more canals.
Code: 3331 **Procedure:** Molar root canal therapy, one canal.

Table 5–3
AOC 63B Procedures—Continued

Code: 3332 **Procedure:** Molar root canal therapy, two canals.
Code: 3333 **Procedure:** Molar root canal therapy, three canals.
Code: 3334 **Procedure:** Molar root canal therapy, four or more canals.
Code: 3335 **Procedure:** Root canal filling removal.
Code: 3340 **Procedure:** Deciduous root canal therapy.
Code: 3350 **Procedure:** Apexification/apexogenesis treatment.
Code: 3410 **Procedure:** Apicoectomy.
Code: 3420 **Procedure:** Retrograde filling.
Code: 3470 **Procedure:** Surgical fenestration (trephination).
Code: 3960 **Procedure:** Bleaching of discolored teeth.
Code: 4210 **Procedure:** Gingivectomy/gingivoplasty.
Code: 4230 **Procedure:** Mesial/distal wedge.
Code: 4240 **Procedure:** Gingival flap.
Code: 4250 **Procedure:** Mucogingival flap.
Code: 4270 **Procedure:** Soft tissue graft.
Code: 4320 **Procedure:** Provisional splint, intracoronal.
Code: 4331 **Procedure:** Occlusal adjustment, complete.
Code: 4361 **Procedure:** Occlusal splint.
Code: 4370 **Procedure:** Hemisection.
Code: 5631 **Procedure:** Maxillofacial prosthesis repair.
Code: 5860 **Procedure:** Overdenture, complete.
Code: 5862 **Procedure:** Overdenture, immediate.
Code: 5864 **Procedure:** Overdenture, partial.
Code: 5866 **Procedure:** Overdenture, partial, cast metal, immediate.
Code: 5872 **Procedure:** Cast metal occlusals.
Code: 6705 **Procedure:** Retainer, cast metal for acid etch bridge.
Code: 7130 **Procedure:** Tooth removal, impacted.
Code: 7150 **Procedure:** Tooth exposure, surgical.

Table 5–3
AOC 63B Procedures—Continued

Code: 7211 **Procedure:** Repair traumatic wounds, simple (over 5 cm).
Code: 7320 **Procedure:** Aveoloplasty.
Code: 7452 **Procedure:** Removal of odontogenic cyst or tumor.
Code: 7462 **Procedure:** Removal of nonodontogenic cyst or tumor.
Code: 7465 **Procedure:** Destruction of lesions.
Code: 7470 **Procedure:** Removal of exostoses.
Code: 7620 **Procedure:** Closed reduction, maxilla or mandible.
Code: 7685 **Procedure:** Intermaxillary fixation.
Code: 7690 **Procedure:** Maxillofacial devices.
Code: 7695 **Procedure:** Arch bar removal.
Code: 7811 **Procedure:** Reduction of dislocation.
Code: 7960 **Procedure:** Frenectomy.
Code: 8121 **Procedure:** Space maintainer, complex, fixed.
Code: 8212 **Procedure:** Habit breaker, mouth breathing.
Code: 8220 **Procedure:** Habit breaker, fixed.
Code: 8311 **Procedure:** Complex Hawley device.
Code: 8410 **Procedure:** Banding.
Code: 8420 **Procedure:** Bonding.
Code: 9235 **Procedure:** Hypnosis.
Code: 9610 **Procedure:** Therapeutic medication by injection.
Code: 9710 **Procedure:** Hospital ward rounds.
Code: 9715 **Procedure:** Grand rounds.

(3) *Periodontics (AOC 63D).* Periodontists (AOC 63D) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2, all procedures identified by code numbers 4000 to 4999 in DA Pam 40–16, and all procedures listed in table 5–4.

Table 5–4
AOC 63D Procedures

Code: 7452 **Procedure:** Removal of odontogenic cyst or tumor.
Code: 7462 **Procedure:** Removal of non-odontogenic cyst or tumor.
Code: 7470 **Procedure:** Removal of exostoses.

(4) *Endodontics (AOC 63E).* Endodontists (AOC 63E) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2, all procedures identified by code numbers 3000 to 3999 in DA Pam 40–16, and all procedures listed in table 5–5.

Table 5–5
AOC 63E Procedures

Code: 7452 **Procedure:** Removal of odontogenic cyst or tumor.
Code: 7462 **Procedure:** Removal of non-odontogenic cyst or tumor.

(5) *Prosthodontics (AOC 63F).* Prosthodontists (AOC 63F) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2. They may provide full mouth rehabilitation and/or therapy using a fully adjustable articulator. They may also perform procedures identified by code numbers 5000 to 6999 and all procedures listed in table 5–6.

Table 5–6
AOC 63F Procedure

Code: 2343 **Procedure:** Laminate veneer facing.
Code: 2420 **Procedure:** Gold foil, Class II.
Code: 2440 **Procedure:** Gold foil, Class IV.
Code: 2542 **Procedure:** Pinledge restoration.
Code: 2610 **Procedure:** Porcelain inlay.
Code: 4320 **Procedure:** Provisional splint, intracoronal.
Code: 4331 **Procedure:** Occlusal adjustment, complete.
Code: 4361 **Procedure:** Occlusal splint.
Code: 9925 **Procedure:** Mandibular recording (three-dimensional).
Code: 9943 **Procedure:** Radiation shield.
Code: 9944 **Procedure:** Radiation needle carrier.

(6) *Public health dentistry (AOC 63H).* Specialists in public health dentistry (AOC 63H) may perform all procedures listed in table 5–2.Duties related to the practice of public health dentistry are nonclinical for which there are no special procedure codes. Nonclinical practice includes conduct of epidemiologic research, health care services research, and dental program planning. Clinical duties associated with these activities are primarily diagnostic and treatment planning already covered by privileges for general dentistry (AOC 63A).

(7) *Pediatric dentistry (AOC 63K).* Pediatric dentists (AOC 63K) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2, all procedures listed by code numbers 8000 to 8999 in DA Pam 40–16, and all procedures listed in table 5–7.

Table 5–7
AOC 63K Procedures

Code: 5960 **Procedure:** Palatal lift prosthesis

Table 5–7
AOC 63K Procedures—Continued

Code: 5970 **Procedure:** Obturator
Code: 5980 **Procedure:** Speech bulb
Code: 9720 **Procedure:** Hospital admissions (as recommended by the MTF credentials committee).

(8) *Orthodontics (AOC 63M).* Orthodontists (AOC 63M) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2 and all procedures listed by codes numbered 8000 to 8999 in DA Pam 40–16.

(9) *Oral and maxillofacial surgery (AOC 63N).* Oral surgeons(AOC 63N) with defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2 and all procedures listed by code numbers 0310,7000 to 7999, and 9000 to 9999.

(10) *Oral Pathology (AOC 63P).* Specialists who have completed specific training in Oral Pathology (AOC 63P) and have defined privileges (para 4–2*a*(5)) may perform all procedures listed in table 5–2 and also those listed in table 5–8. Officers trained in oral medicine (AOC 63C) and who have been converted to (AOC 63P) may perform all procedures listed for AOC 63P except 0450 and 0451. These procedures may be requested if training, experience, or certification provide justification.

Table 5–8
AOC 63P Procedures

Code: 0141 **Procedure:** Postmortem examination or bite mark analysis for identification.
Code: 0310 **Procedure:** Sialography.
Code: 0450 **Procedure:** Macroscopic tissue examination (requires training, experience, or certification in oral pathology).
Code: 0451 **Procedure:** Microscopic tissue examination (requires training, experience, or certification in oral pathology).

(11) *Residency dentists.* Residents will perform procedures assigned and monitored by their mentor.

(12) *Dental assistants.* Dental assistants who have completed a structured training program in dental prophylaxis under the direction of a dental officer may perform removal of exogenous stain, plaque, and supragingival calculus, procedure codes 1110 and 1120. All treatment will be performed under the direction and supervision of a dental officer.

(13) *Preventive dentistry specialist (330–X2) (or local national personnel with equivalent education).* To meet the qualifications of preventive dentistry specialists, individuals must—

(a) Be a graduate of the military training program.

(b) Perform all treatments under the guidance and supervision of a dental officer.

(c) Be able to perform procedures listed in published policies and AR 611–201.

(d) Be able to perform the preventive and oral hygiene procedures in table 5–9.

Table 5–9
330–X2 Procedures

Code: 1110 **Procedure:** Adult prophylaxis.

Table 5–9
330–X2 Procedures—Continued

Code: 1120 **Procedure:** Child prophylaxis.
Code: 1240 **Procedure:** Topical fluoride, professional application.
Code: 1245 **Procedure:** Topical fluoride, self-applied, group.
Code: 1330 **Procedure:** Individual oral health counseling.
Code: 1331 **Procedure:** Group oral health counseling.
Code: 4342 **Procedure:** Periodontal scaling.

(14) *Dental assistant (expanded function).* To meet qualifications as dental assistants (expanded function), individuals must—

(a) Be graduates of an accepted dental therapy assistant program-(dental assistant, expanded function).

(b) Perform treatments under the guidance and supervision of a dental officer.

(c) Perform treatments that will be reversible and limited to those procedures listed in published policies, and Occupational Code GS 681.

(d) Be able to perform those preventive and oral hygiene procedures in table 5–9.

(15) *Dental Hygienist (GS 682).* To meet qualifications as dental hygienists, individuals must—

(a) Be a graduate of an acceptable dental hygiene program which qualifies them to obtain a State license.

(b) Perform treatments under the guidance and supervision of a dental officer.

(c) Perform treatments that will be limited to those procedures listed in published regulations, policies, and Occupational Code GS 682.

(d) Be able to perform those preventive and oral hygiene procedures in table 5–9.

(e) Be able to perform the periodontal scaling and root planing procedure listed under code 4343.

(f) Have a State license effective 18 July 1989.

Chapter 6
Reserve Components

6–1. Policy

a. The RCs will comply with the QAP as outlined in this regulation.

(1) RC members providing medical or dental care who are given the responsibility for making independent decisions to initiate or alter a regimen of treatment will be privileged (para 4–1).

(2) Members will not be granted clinical privileges until all appropriate documents are available to validate the member's education, training, experience, licensure or certification, and current competence. In no instance may a member be assigned or privileged to perform professional duties unless qualified by education, training, and experience.

(3) A PCF will be established and maintained for privileged members.

(4) The PCF will be initiated upon entry into the AMEDD and maintained until discharge or retirement.

(5) The quality and appropriateness of patient care services provided will be monitored and evaluated on an ongoing basis.

(6) An RC practitioner having an adverse privileging action, resulting in a permanent restriction or revocation of clinical privileges, will be considered for reclassification, branch transfer, or separation. Commanders will review cases of assigned practitioners and recommend disposition according to appropriate regulations, dependent upon the nature and merit of each case.

b. The quality and appropriateness of patient care services provided by RC practitioners will meet the standards established by the AMEDD.

(1) The DHS will develop a scope of practice for RC practitioner privileges for each of his or her facilities within the health service region.This scope of practice will outline, as a minimum, clinical privileges, types of drugs to be used, scope of medical care to be given, and patient evaluation procedures.

(2) Coordination will be made between the DHS (or designated representative) and RC units to address the written QA mechanisms to be used at training sites during unit training and medical site support missions.

c. RC units will ensure that all field medical training conducted at State-owned or -operated training installations or active component installations is coordinated with the DHS in consonance with the type of training being conducted.

6–2. Credentials committee

a. The number of committee members will be determined per paragraphs 2–1*b* and 5–2*b*, as appropriate.

b. ARNG medical units and USAR troop program medical units having enough practitioners from the same discipline (MC and DC) assigned and participating in unit training assemblies will form a credentials committee per paragraph 2–1*b* and will monitor, review, and update the PCF.

c. The RC credentials committee will make recommendations on the scope of individual clinical privileges to be granted by the MEDDAC, MEDCEN, or DENTAC credentials committee. These recommendations will be recorded on DA Form 5753–R and forwarded to the MEDDAC, MEDCEN, or DENTAC credentials committee together with a current PCF. DA Form 5753–R will be reproduced locally on 8½- by 11-inch paper; a copy of this form for reproduction is located at the back of this regulation.

d. For units not having enough members to form a credentials committee, the PCF will be forwarded for review and updated by one of the following:

(1) The nearest RC medical unit that has a committee.

(2) The unit designated by the command surgeon at the next higher headquarters.

(3) The ARNG State surgeon, as designated by the adjutant general (AG) of the respective State or the AG's designee for QA.

e. Upon completion of review and update, the PCF will be returned to the designated unit for maintenance per paragraph 6–3.

6–3. Practitioner credentials file

a. A PCF will be maintained for all practitioners per paragraphs 4–6*b* and 4–11.

b. PCF maintenance will be determined by RC status.

(1) PCF maintenance for ARNG members is the responsibility of the respective State adjutant general (AG) or the AG's designee for QA, the ARNG State surgeon. The PCF for ARNG unit members will be maintained by specific personnel designated by the unit commander, the ARNG State surgeon, or State AG.

(2) The PCFs for USAR troop program units (TPUs) members will be maintained by specific personnel designated by the medical unit commander or by the command surgeon at the next higher headquarters.

(3) The PCF for Individual Ready Reserve (IRR) members will be maintained by the Army Reserve Personnel Center (ARPERCEN) QAC.

(4) The PCF for Individual Mobilization Augmentee (IMA) members will be maintained by the agency to which they are assigned.

c. The custodian of the RC PCF will ensure that copies of any adverse privileging actions taken by the civilian medical or dental facility where the member is employed or practicing are included in the PCF. Copies of actions will be sent within 3 working days of receipt to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church,

VA 22041–3258 (para 6–10). For ARNG, the PCF custodian will send the copies through TAG, ATTN: State Surgeon and MILPO. Telephonic notice of receipt of the action will be made to SGPS–PSQ (AV 289–0088; commercial (703) 756–0088) prior to mailing the copies.

d. The PCF will be forwarded to the military health care facility per paragraph 6–4 below.

e. Upon completion of ADT or its equivalent by RC practitioners, the QAC or credentials specialist at the facility will return the PCF by certified mail, return receipt requested, to the appropriate unit commander or administrative headquarters responsible for custody of the PCF. The PCF will not be handcarried by the practitioner.

f. For disposition after the practitioner ends his or her service, see AR 25–400–2, FN 40–66d.

g. Transfer of PCF will be per paragraphs 4–3*a* and 4–11*c*. Upon notification of reassignment of a practitioner, the original PCF will be sent directly to the gaining unit. The losing unit will retain a copy of the PCF for a minimum of 1 year. If the PCF contains any adverse information, a copy of the PCF will also be sent to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Transmittal of PCFs will be by certified mail, return receipt requested.

6–4. Availability of updated PCFs for active duty training or equivalent training

a. The PCF will be made available to the facility by the custodian at least 45 days before the scheduled arrival of the practitioner. If the 45-day timeframe cannot be met, exceptions will be coordinated directly between the two activities. When the frequency of performance of duty or training precludes sending the original PCF, a legible certified true copy will be sent. Upon completion of the duty or training, the certified copy will be returned to the custodian unless required for ongoing privileges.

b. Additions to the PCF while on duty or training will be sent to the custodian of the parent unit for updating of the original PCF. The custodian is responsible for providing updated information to all military facilities where the practitioner has ongoing privileges.

6–5. Issuance of orders

a. RC HCPs will not be accepted for inactive duty training (IDT), ADT, annual training (AT), or active duty for special work (ADSW) as practitioners (privileged) by Active Component (AC) MEDDACs, MEDCENs, or DENTACs until the facility QAC notifies the HCP's responsible agency that all PCF documentation is in order.

b. An ARNG HCP will not be issued orders for IDT, ADT, AT, or full-time training duty as a practitioner (privileged) with an AC MEDDAC, MEDCEN, or DENTAC unless an updated PCF is available to the facility commander at least 45 days prior to scheduled arrival of the HCP for duty at the facility.

c. AC MEDDAC, MEDCEN, or DENTAC commanders will ensure that PCFs for RC practitioners are reviewed expeditiously and that prompt notice of review is provided the PCF custodian so that appropriate personnel actions may be carried out. Delays in reviewing PCFs and notifying the PCF custodian that the documentation is in order could preclude the practitioner's availability for duty.

6–6. Preselection verification

a. A preselection verification of education, training, and licensure, certification, or registration will be made per paragraph 4–6. For the active duty practitioner who joins the ARNG or USAR, the PCF from the last MEDDAC, MEDCEN, or DENTAC of appointment will be used. With the exception of current unrestricted licensure status, items in the PCF need not be reverified when there is documentation to support validation.

b. There will be statements of past and current medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard professional practice (for example, privilege limitations, revocations, or modifications at any hospital; resignation from any hospital staff; refusal of membership on a hospital staff; suspension or revocation of a narcotics registration; disciplinary action by any local or State professional society, licensing agency, or other regulatory agency).

c. The appointee will submit a statement indicating the scope of current civilian practice including any civilian hospital clinical privileges.

d. A copy of the appointee's Federal narcotics license, if applicable, will be submitted.

e. The above validated documents will become a part of the RC member's PCF. The AMEDD Officer Procurement Division (HQDA (SGPS–PD), 5109 Leesburg Pike, Falls Church, VA 22041–3258), will provide certified true copies of documents to the RC practitioner's first unit of assignment. The documents will be sent by certified mail, return receipt requested.

6–7. Privileging

a. Procedures.

(1) Members will complete the front only of DA Form 4691–R (for appointees only at time of initial application for privileges) and submit it when requested by the unit's credentials committee or other appropriate credentials committee (para 6–2). Nonunit members will submit DA Form 4691–R to the QAC, ARPERCEN.

(2) DA Form 5440–R-series will be completed at the member's duty station. Separate forms will be completed for periods of ADT, AT, or IDT since the extent to which privileges are granted may differ based upon type and length of duty performed. Forms must also be completed for each facility in which the practitioner seeks privileges. For members of the IRR performing duty at a MEDDAC, MEDCEN, or DENTAC, DA Form 5440–R-series will be completed and become a part of the PCF prior to transmittal to the duty station.

(3) DA Form 5753–R will be used by RC practitioners to apply for clinical privileges during periods of active and inactive duty for training (AT, ADT, ADSW, IDT, or equivalent). The type of duty (active or inactive) being performed that is not applicable will be marked out where appropriate. The form will be completed for each facility in which privileges are sought for each active duty period of 5 or more consecutive days. For periods of IDT, the form will be completed once annually for each facility in which privileges are sought. If a practitioner customarily performs duty at the same facility, the same form may be used for an extended period of time and be updated at the discretion of the credentials committee, but the extended period may not exceed 2 years.

(4) The original DA Forms 4691–R, 5440–R-series, and 5753–R will become a part of the member's PCF and a copy will be given to the practitioner.

b. MEDDAC, MEDCEN, or DENTAC training. RC practitioners who will participate in training at a MEDDAC, MEDCEN, or DENTAC will have their PCF reviewed and privileges granted by that facility's credentials committee (see para 6–5). When a practitioner is not awarded privileges or privileges are restricted due to professional incompetence, HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258, will be notified (para 4–9*k*). (The scope of privileges may be limited due to the inability of the medical or dental facility to support specific practices. Such limitation will be described in the Remarks section of DA Form 5440–R-series.) HQDA (SGPS–PSQ) will notify the following, as appropriate:

(1) For ARNG members (through the Chief, National Guard Bureau, ATTN: Chief, Office of the Army Surgeon), The Adjutant General, ATTN: State Surgeon and military personnel office (MILPO), of the applicable State.

(2) For IRR and IMA, ARPERCEN.

(3) For USAR TPU members, Forces Command (FORSCOM).

c. Remote site training and medical site support.

(1) RC practitioners at sites removed from the MEDDAC, MEDCEN, or DENTAC are also subject to credentials review and privileging per paragraph 6–1.

(2) The standard scope of practice for practitioners at these sites

will be based on DA Form 5440–26–R-series (Delineation of Privileges—Troop Medical Clinic).

(3) Practitioners will submit DA Form 5440–26–R-series, DA Form 5753–R, and current PCFs to the regional medical or dental facility responsible for operation of the site during specific training periods.

6–8. Evaluation and reappointment

a. Procedures.

(1) Evaluation and reinstatement or modification (augmentation or restriction) of clinical privileges will be based on education, training, experience, thorough appraisals of clinical performance, professional conduct, and health status. Evaluations will normally be done during annual training or following each active duty period of 5 or more days.

(2) DA Form 5441–26–R-series (Evaluation of Privileges—Troop Medical Clinic) will be used to evaluate each active duty training period. For practitioners who participate in an inactive duty status, evaluation will be made following the completion of a minimum of 24 nonconsecutive inactive duty days. DA Form 5374–R will be used to evaluate periods of inactive duty for training. This process allows for evaluation of performance to be completed, giving consideration to current policies regarding fragmented training or excuses from training. The original of the forms will be kept in the PCF and a copy given to the practitioner.

(3) Except for evaluations of each active duty period of 5 or more consecutive days, evaluation of practitioners is required once annually.

b. Remote site training and medical site support. Medical or dental care will be evaluated. For evaluation of practitioners at remote sites, the DHS may request the RC "on-site" medical unit commander to certify by letter at the completion of annual training that care assessed by current QA methodology met the required standards. In other training units where the commander cannot certify to the quality of care being provided, the DHS has the following courses of action available:

(1) Conduct site visits using representatives from the MEDDAC, MEDCEN, or DENTAC.

(2) Accept certification by the on-site clinical officer in charge that the quality of care provided by his or her RC unit or practitioner meets established requirements mandated by practitioner credentials, the scope of practice, and standards of care. This certification is dependent upon having a medical or dental staff of three or more officers who may conduct peer review at the RC treatment facility.

(3) Require a retrospective medical record review of clinic visits be done by the DHS representative. At least 10 percent of records, but no less than 50 records will be reviewed for quality and appropriateness of care.

(4) DA Form 5374–R or DA Form 5441–26–R-series may by used to record performance evaluation based on type of duty as discussed in *a* above.

6–9. Suspension, restriction, or revocation of clinical privileges

a. RC practitioners are subject to suspension, restriction, or revocation of clinical privileges per paragraph 4–9. The agency initiating the adverse privileging action will send a copy of DD Form 2499 (RCS DD–HA(AR)1611) to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258, and forward information copies to all levels of medical commands including the respective major Army command (MACOM); (for the ARNG, through the State AG to the Chief, National Guard Bureau, ATTN: Chief, Office of the Army Surgeon, WASH DC 20310–2500). (See para 6–10.)

b. Proceedings (hearing rights and appeals process) will be carried out per paragraphs 4–9 and 4–10. TSG will be the final appeal authority (para 4–10). Travel costs to the practitioner incidental to the appeal process will be coordinated through the practitioner's higher headquarters. Initiation authority for adverse privileging actions based on practitioner assignment and type of training are as follows:

(1) For all RC members performing duty (regardless of type) in a MEDDAC, MEDCEN, or DENTAC, the commander of that facility will initiate the actions.

(2) For Active Guard Reserve (AGR) members not assigned to a TPU of the RC, the actions will be initiated by the commander of the unit to which they are assigned or attached. Other AGR members are covered by the provisions of (1) above.

(3) For IMA members, the commander of the unit to which they are assigned will initiate the actions.

(4) For IRR members not attached to another unit and assigned to ARPERCEN and not performing duty, the commander, ARPERCEN, will initiate the actions.

(5) For IRR members attached to or performing duty at other than a TPU, if the practitioner is in a medical unit, the actions will be initiated by the unit commander. If the practitioner is not in a medical unit, the next higher medical command or command having medical authority will initiate the actions.

(6) For ARNG members assigned to a medical unit, the actions will be initiated by the unit commander. If the practitioner is not assigned to a medical unit, the actions will be initiated by the next higher command having a medical authority.

(7) For USAR members assigned or attached to a medical TPU, the unit commander will initiate the actions. If the practitioner is not assigned to a medical TPU, the next higher command having a medical authority will initiate the actions.

(8) Documents for appeal and continued action will be forwarded to the next higher MEDCOM or command having a medical authority. The following are exceptions:

(a) For ARNG, forward appeals to the State adjutant general.

(b) For IRR members, forward appeals directly to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(9) If action by the higher headquarters above results in further appeal, documents will be forwarded to HQDA (SGPS–PSQ).

(10) In no case will there be more than one level of appeal or continued action between initiating the adverse privileging action and TSG (final appeal authority).

(11) For purposes of initiating adverse privileging actions, processing appeals, and continued action, if the next higher command is not a medical unit (or is a medical unit without sufficient medical assets assigned to convene the required committees), the higher commander having a medical authority available will direct that the necessary assets from within his or her command be used to convene the committees to meet the requirements of this paragraph.

c. All adverse privileging actions will become a part of the practitioner's PCF.

d. When action has been taken to restrict an RC practitioner's privileges and the practitioner is no longer performing the normal duties of his or her specialty practice, the RC commander will give consideration to separation or actions to changes in AOC and special pays.

6–10. Reporting requirements

a. All reporting requirements per paragraph 4–9*k* apply with the modifications indicated below.

b. When reports are initiated by a MEDDAC, MEDCEN, or DENTAC, copies of the reports will be sent to the following:

(1) For USAR TPU members, the USAR TPU commander maintaining the PCF.

(2) For USAR IRR members, the ARPERCEN QAC.

(3) For IMA members, the IMA facility maintaining the PCF.

(4) For ARNG members, through the State AG to the attention of the State surgeon and MILPO, to the custodian of the PCF.

c. When reports are initiated by the RC unit commander, copies of the reports will be sent to the following:

(1) The custodian of the PCF.

(2) All military facilities where the practitioner currently has privileges.

(3) Through the appropriate RC command channels; for example,

State Surgeon, U.S. Army Reserve General Officer Command (GOCOM), U.S. Army Reserve Command (ARCOM) Surgeon, Army Area Medical Adviser, and so forth.

(4) For USAR, to the ARPERCEN QAC.

d. Concurrent with the transmittal of the adverse privileging actions (DD Form 2499) through appropriate channels, an information copy of the action will be transmitted to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

6–11. DA Form 5753–R

a. A current completed DA Form 5753–R will be made available per paragraph 6–4.

b. Any yes answers under interval information will serve as a flag—an indicator to look more carefully and try to determine whether or not there are any quality of care concerns.

(1) Under liability judgments and liability payments, determine whether the field of practice is fraught with the potential for bad results; for example, high-risk patients. Determine also whether it was a one-time episode with no finding of "gross or repeated malpractice," or whether there is a recurring pattern.

(2) The unit commander will make his or her recommendation to the MEDDAC, MEDCEN, or DENTAC credentials committee based in part on the findings of (1) above. The credentials committee will then make its recommendation to the MEDDAC, MEDCEN, or DENTAC commander.

c. If the findings from the evaluation of the interval information show derogatory information and the credentials committee recommends adverse privileging action, action will be initiated per paragraph 6–9.

Chapter 7
Impaired Health Care Provider Program

7–1. General

This chapter establishes policies and procedures for the Impaired Health Care Provider Program, an important element in the QAP. This program is in compliance with all provisions of AR 600–85 and adds those elements necessary to provide quality patient care. This program applies to all AMEDD active duty military officers, warrant officers, and civilian employee officer-equivalent HCPs who are licensed or privileged and provide or supervise direct patient care.

7–2. Objectives of the Impaired Health Care Provider Program

The objectives of the program are to—

a. Prevent impairment and promote well-being of HCPs through education and minimize factors that contribute to impairment.

b. Identify impairment in HCPs as early as possible in order to promote recovery and ensure patient safety.

c. Provide a mechanism for limiting the clinical practice of impaired HCPs, whether or not privileged.

d. Provide a mechanism for return to clinical practice (when feasible) for HCPs who have been successfully rehabilitated.

e. Provide a mechanism for ongoing monitoring of rehabilitated HCPs.

7–3. Management of health care providers impaired by medical or psychiatric problems

a. Any HCP known or suspected of having a medical or psychiatric problem that impairs (or could potentially impair) clinical performance will be reported to the impaired provider ad hoc committee (para 2–3).

b. The ad hoc committee will request the following:

(1) A statement of diagnosis, prognosis, and implications for clinical performance from a physician (preferably the primary physician treating the provider).

(2) A statement concerning current clinical performance from at least one immediate supervisor or professional peer.

(3) Recommendations regarding the HCP's scope of clinical practice from the appropriate department or service chief.

c. The impaired provider ad hoc committee will review these statements and recommendations and recommend limitations of practice, as necessary. If the HCP has privileges, these recommendations will be submitted through the MEDDAC, MEDCEN, or DENTAC credentials committee to the commander. Otherwise the recommendations will be made directly to the commander. If the HCP's clinical practice is suspended or restricted, notification of action will be made per paragraph 4–9*k*.

d. In cases of chronic disease, at the time of privileges reappraisal or if a change occurs in the health of the provider, reports of the HCP's health will be required from the designated physician and supervisor or designated professional peer. For the privileged HCP, these reports will be maintained in the PAF. Otherwise, the reports will be maintained in a confidential (para 1–7), temporary QA file that will be destroyed when the HCP is successfully returned to full clinical practice. (See AR 40–400–2, FN 40–1a.) If a change of duty station occurs prior to the return to full practice, this file will be sent to the gaining facility in the same manner as the PCF (para 4–3*a*).

e. Upon report of recovery, the impaired provider ad hoc committee will again request and review statements from a physician, at least one immediate supervisor or professional peer, and the department or service chief. The committee will then make recommendations to the credentials committee or commander regarding the removal of limitations on clinical practice.

7–4. Management of HCPs impaired by alcohol or other drug abuse or dependence

a. Abuse and dependence. Alcohol and other drug abuse or dependence as described in the current Diagnostic and Statistical Manual III may lead to impairment and the subsequent need for rehabilitation.

b. Impaired provider reporting. Any HCP known or suspected of having an alcohol or other drug abuse or dependence problem will be reported to the impaired provider ad hoc committee (para 2–3). (See *c*(2) below.)

c. Program components. The provisions of AR 600–85 apply fully to HCPs impaired by alcohol or other drug abuse or dependence. In addition, the following will apply:

(1) *Prevention.*

(a) Because HCPs are at increased risk for drug abuse or dependence, all MEDDACs, MEDCENs, and DENTACs will develop a prevention and identification plan. The plan will incorporate elements of deglamorization, widespread publicity, education, and quality assurance. The plan will be developed in conjunction with the installation clinical director.

(b) Drug abuse by HCPs will be considered an occupational hazard. Educational programs will place special emphasis on aspects of drug abuse for those working with pharmaceuticals of addictive potential. In addition, mechanisms for storing and handling of controlled drugs will be periodically reviewed. When a drug diverting situation occurs, the general problem of drug diversion should also be addressed by the MEDDAC, MEDCEN, or DENTAC QA committee. Lessons learned should be sent to major MEDCOM QA offices. (It should be noted that diversion and abuse is criminal misconduct and law enforcement involvement is appropriate.)

(c) HCPs, especially those in psychiatry, family practice, primary health care, and emergency medicine will be educated in all aspects of alcohol or other drug abuse or dependence as part of an ongoing inservice education program. HCPs should, when feasible, participate in a didactic and experiential orientation at a residential treatment facility (RTF).

(d) Inservice education programs will emphasize—

1. That HCPs, despite their health care background, are as vulnerable or more vulnerable to alcohol or other drug abuse or dependence than the general public.

2. The importance of learning and implementing healthy coping mechanisms for dealing with the stresses that often contribute to the

development of alcohol and other drug abuse or dependence among HCPs.

3. The RM implications of HCPs continuing to provide or supervise direct patient care while impaired.

4. Decision-making skills and risks regarding the use and misuse of alcohol and drugs.

5. The role of denial as a symptom of and a functional part of alcohol or other drug abuse or dependence in HCPs and how this is compounded by the silence of colleagues, supervisors, and even patients.

6. Recognition of early behavioral and job performance indicators of alcohol or other drug abuse or dependence.

7. Principles of effective intervention and content of treatment programs used by impaired HCPs and their families.

8. The responsibility of peers and supervisors to report HCPs who abuse or are dependent on alcohol or other drugs to the impaired provider ad hoc committee.

9. The threat to the career, health, and even the life of the HCP if the impairment is allowed to continue.

10. The high success rates of treatment and the return to full clinical practice after treatment, especially when identified early.

(e) HCPs who have been through treatment and have been recovering for at least a year should be considered to assist in teaching educational programs.

(f) QAP activities should include identification of policies or particularly stressful work environments that may contribute to the use of alcohol or other drugs by HCPs.

(2) *Case-finding.* Case-finding results from a sensitivity to the problem and ongoing monitoring of HCPs' clinical practice. All HCPs are required to report providers whose clinical practice is impaired or potentially impaired through the department chief to the impaired provider ad hoc committee. The department chief will review the report and inform the committee whether monitoring or confrontation will be employed. In either case, the clinical director will be notified and involved in the process. For civilian HCPs, in addition to the CCC civilian program coordinator, the management-employee relations representative from the CPO will be informed. Civilian HCPs experiencing job performance problems will be informed of the appropriate course of action that will be taken.

(a) Monitoring will be used only when there is no clear evidence with which to confront the HCP. If monitoring is chosen, a memorandum for record (MFR) will be sent to the committee describing the circumstances and specifying the type of monitoring that will be done.

(b) If evidence of job impairment exists, confrontation is recommended. In this situation, the supervisor will meet with the HCP and objectively confront him or her with the evidences of impairment. Clear expectations of future performance will be given. The confronted HCP will also be referred to the CCC for a full evaluation. If confrontation is chosen, an MFR will be sent to the committee describing the evidence, the future expectations as given, and the HCP's response. In no circumstances will an HCP be questioned about the impairment or the causes thereof without appropriate advice concerning the HCP's Article 31, UCMJ, and other rights, as appropriate.

(3) *Intervention.*

(a) Intervention process. Intervention involves confrontation leading to a requirement for the impaired HCP to enter treatment. Intervention is used when the behavior that impairs or potentially impairs clinical performance is clearly related to alcohol or other drug abuse or dependence. When intervention is chosen—

1. The CCC will be notified in advance of any action being taken so the therapist can lend consultation and assistance. The CCC will process ADAPCP enrollment and admission to an RTF program, if appropriate. (A medical evaluation is necessary per AR 600–85 prior to admission to an RTF.)

2. The MEDDAC, MEDCEN, or DENTAC commander will institute enrollment of an active duty HCP into a treatment program if that provider refuses to enter treatment. (If the impaired HCP is a civilian employee, the civilian program coordinator of the CCC and CPO will be notified prior to the intervention.) Consequences for refusal to enter treatment will be given in advance.

(b) Scope of clinical practice. The HCP's clinical practice parameters will be reviewed immediately by the impaired provider ad hoc committee, in coordination with the credentials committee when appropriate. The HCP will be removed from direct patient contact (para 4–9*a*) until the committee determines that the problem is satisfactorily controlled. Impaired HCPs requiring inpatient treatment will have their clinical practice reevaluated upon return to the duty station.

(c) Followup. Care will be taken that an HCP who has been confronted has an adequate support system at home or is hospitalized.

(4) *Treatment.*

(a) Need for treatment. Neither the type of drug nor the type of use of the drug alone determines the need for treatment. Apart from the legal ramifications, drug abuse could range from simple experimentation to psychological or physical dependence. All identified abusers will be immediately referred to the CCC for evaluation. Assessment of the need for treatment and the level of treatment will be made by the CCC independent of administrative or legal concerns.

(b) Types of treatment. Inpatient (residential) treatment of active duty HCPs will be offered through the Army RTF if the provider has potential for retention on active duty, or may be offered through the Department of Veterans' Affairs if separated from active duty. If detoxification is necessary, it will be accomplished per AR 600–85, paragraphs 4–17 through 4–19. Outpatient treatment and education will be available from the CCC to all impaired HCPs, military and civilian. Civilians may also be treated as outpatients in civilian outpatient or residential programs through the Federal Employee's Health Benefits Program or other commercial insurance programs.

(c) Coordination of treatment. Treatment will be coordinated by the CCC for active duty and civilian personnel under AR 600–85. The family will be included in the treatment plan. Administrative or legal charges that may interfere with treatment should be resolved prior to admission to an RTF. For those who do not enter an RTF and those awaiting the decision of administrative or legal charges, a binding outpatient plan will be developed with the requirements per (5) below.

(5) *Aftercare.* Aftercare is the program of activities in the remainder of the 1-year enrollment following a residential program. The program is designed to promote long-term recovery. The aftercare plan will be developed prior to discharge from the RTF. The CCC therapist will coordinate a rehabilitation team meeting as soon as the HCP returns to duty to review the plan and agree on its specifics. The commander, supervisor, HCP, and impaired provider ad hoc committee will be given a copy of the plan. The aftercare plan will be binding and consequences of not following the plan will be clearly documented.

(a) The plan will include the provision that the HCP shows evidence of—

1. Attendance at Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), or similar approved support group at least 3 times weekly.

2. Taking of Antabuse, if prescribed.

3. Participation in the CCC groups, educational classes, and individual sessions as described in the plan.

4. Random testing for drug problems. Urine samples will be collected by the CCC from HCPs with drug problems. The samples will be tested for the specific drug abuse, if possible. Such testing will be done weekly for the first 6 months and twice a month for the next 6 months. In the second year the commander, in coordination with the ADAPCP, will ensure that monthly drug testing is done. The test results will be reported to the impaired provider ad hoc committee.

(b) Evidence of compliance with the above will be given to the impaired provider ad hoc committee monthly for 1 year after entry into treatment and at least quarterly for a second year.

(c) In the event of a relapse (return to alcohol or drug use) the

HCP will be immediately suspended from clinical duties per paragraph 4–9*b*. A full reassessment will be made to include an evaluation of progress to this point and circumstances surrounding the relapse (precipitating factors plus the HCP's use of recovery coping skills). If a second admission to an RTF is recommended, approval must be obtained from the major MEDCOM clinical drug and alcohol office.

(d) Tours of active duty for impaired HCPs will be stabilized at least 12 months from the date of admission to the RTF under AR 614–5. Exceptions are in cases where the community does not possess sufficient aftercare resources or where there are insufficient HCPs in the same work role as the recovering provider. Major leadership positions and solo practices are to be avoided. In these cases an exception to policy will be initiated so the HCP can be reassigned to an appropriate duty station.

(e) To allow time for transition into the followup phase of rehabilitation, requests for leave should generally not be approved until 60 days after discharge from an RTF.

(6) *Re-entry.* Re-entry refers to the HCP's return to duty and reentry into clinical practice. Reinstatement to full clinical practice will normally be a gradual process. Return to full practice depends upon the circumstances of the case and the HCP's responses to treatment and aftercare. Determination will be made by the commander based on the recommendations from the impaired provider ad hoc committee in coordination with the credentials committee, when appropriate.

(a) HCPs who have abused controlled drugs are generally restricted from prescribing or administering controlled drugs after return from treatment.

(b) As long as progress is satisfactory, the HCP should eventually be returned to full clinical practice in the same role previously held. However, HCPs working in anesthesiology should not generally return to this specialty when their impairment has been addiction to drugs. Exceptions can be made after a substantial period of highly successful aftercare and the return to anesthesia is recommended by the CCC clinical director. Extended monitoring will be done in these cases.

(c) If, in the opinion of the department chief, impaired provider ad hoc and credentials committees, therapists, and the active duty HCP concerned, a return to the previous specialty is not appropriate, a recommendation for change of AOC will be initiated. Approval rests with the appropriate corps chief.

(d) In no case will the recovering HCP be used in inservice education on alcohol and drug abuse or dependence until 12 months following the onset of treatment.

(7) *Ongoing monitoring.* Ongoing monitoring refers to the observations, reports, and meetings required over a 2-year period to assess the progress of the HCP who has returned to duty. The CCC is involved in monitoring during the first year of aftercare. The supervisor, department chief, and impaired provider ad hoc committee will continue monitoring for a second year. The committee will review the progress of each impaired HCP monthly for the first 3 months of treatment and at least quarterly thereafter until 2 years from the date of return to duty.

(a) Reports.

1. The CCC will submit monthly written reports to the impaired provider ad hoc committee for the first 3 months and quarterly thereafter while the HCP is in aftercare. These reports will state, at a minimum, the HCP's compliance with the aftercare plan, current progress, and prognosis. The reports will be forwarded to the credentials committee for privileged HCPs.

2. The immediate supervisor or designated peer will submit a reports regarding the HCP's duty competence to the CCC monthly during the first 3 months and quarterly thereafter until completion of aftercare monitoring.

3. Reports sent to the credentials committee will be maintained in the PAF. Reports on HCPs not privileged will be maintained in a confidential, temporary QA file (para 1–7), which will be destroyed when the HCP is successfully returned to full practice. If a change of duty station occurs prior to the return to full practice, these files will be transferred to the gaining facility per paragraph 4–3*a*.

(b) Individuals monitoring impaired HCPs will notify the supervisor and therapist immediately upon signs of relapse or failure to follow the aftercare plan. Proper action will be taken promptly for the good of the HCP as well as the safety of the patient population.

(c) The confidentiality requirements of AR 600–85 apply to all reports, committee minutes, and discussions pertaining to impaired HCPs in the Army's ADAPCP. Civil penalties apply for unauthorized disclosure. (See para 1–7 and AR 40–66, para 2–7.)

(8) *Program termination.*

(a) Professional involvement. The CCC's role in the HCP's recovery program ends 1 year after enrollment. The role of all others generally ends after the second year. At this time the impaired provider ad hoc committee will recommend termination of monitoring unless review findings or relapse require further involvement.

(b) Processing for separation. AR 600–85 requires that all military personnel, E5 and above, who are identified as drug abusers be processed for separation from the Army per AR 635–100 and AR 635–200. The unit commander initiates the separation process. Each level of command to the general courts-martial convening authority (GCMCA) recommends approval or disapproval of the separation. The GCMCA is the first level at which the separation process can be stopped and the HCP retained on active duty. However, the GCMCA may request determination by a DA board.

7–5. Notification to professional regulating authorities

a. Notification will be made per paragraph 4–9*k* for HCPs who are privileged. For nonprivileged HCPs, reports will be sent through the next higher headquarters to HQDA (SGPS–FP), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Major MEDCOMs will notify their drug and alcohol clinical offices of all cases of impairment.

b. Notification will be made for any HCP who—

(1) Has clinical practice suspended, limited, restricted, or revoked.

(2) Possesses, prescribes, sells, administers, gives, or uses any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes. (See para 4–9*k*(5).)

(3) Separates from active duty or Federal Service in a less than full (defined) clinical practice.

(4) Leaves at any time for any reason during the 2-year monitoring period.

c. TSG is the reporting authority.

Chapter 8
Alcohol and Drug Abuse Prevention and Control Program and the Community Counseling Center Quality Assurance Program

8–1. General

a. QA plan. Each CCC will develop a QA plan as described in paragraph 3–1 and coordinate with the MTF QA committee. The plan will describe all QA activities that occur in the ADAPCP in the categories of patient care evaluation, utilization management, risk management, and privileging.

b. Clinical services. The outpatient clinical services of the ADAPCP will be provided in the CCCs by qualified clinical staff who are DA certified as alcohol and drug counselors and are under the supervision of the clinical director who is privileged by the MTF.

c. Problem resolution and followup.

(1) *Problem resolution.* When problems in patient care or opportunities to improve care are identified, action will be taken. The problems will be prioritized based on the potential impact on patient care and outcome, number of patients affected (high volume) or single major event, and cost-effectiveness of problem-solving. The CCC QA committee or clinical director will assign the identified problem to a specific person or group within the CCC. The assigned party will assess the problem fully (to include conducting studies or

surveys, if necessary) and report findings and recommendations to the committee. The committee will implement corrective action. Problems that cannot be resolved within the CCC will be referred to an appropriate resource and documentation of this referral will be made on the QA accession log (*d*(2) below) and followed until resolution. If corrective action does not occur within the established timeframe, the clinical director will advise the MTF QA committee.

(2) *Followup.* The CCC QA committee or clinical director will monitor the problems where corrective action has been taken to verify correction of practice or satisfactory resolution. Elements of this process may include performing a new study using the same, new, or revised assessment criteria, or reviewing data collected after corrective action is taken. If an area of clinical care has not been satisfactorily corrected, the problem will again be reviewed by the CCC QA committee for further evaluation and appropriate action.

d. Reports and forms.

(1) *Minutes.* QA activities will be reported at least monthly either as part of the regularly scheduled staff meeting or as a part of a separate CCC QA committee meeting. (See para 2–2 for recording of minutes.) Minutes will be reported through the CCC QA committee to the MTF QA committee per the calendar of reports (table 2–1).

(2) *QA accession log.* QA accession logs will be maintained to monitor problems. The problem, original disposition, final resolution, and followup will be recorded. Problems will be numbered by year, month, and sequence; that is, 88–2–1, 88–2–2, 88–5–1. Data sources include monitoring activities, medical record review, incident reports, utilization review studies, patient and staff surveys, and so forth.

e. Communication and use of findings. Findings from QA activities will be communicated to the entire staff. Findings will also be used in the reappraisal of privileges, performance evaluations, and development of staff educational programs. Special attention will be given to those staff members experiencing difficulty in the delivery of quality patient care.

f. Annual evaluation. During the first meeting of each year, the CCC QA committee will conduct a review of the objectives, scope, organization, and effectiveness of the QAP, and revise it as necessary. The annual evaluation will be recorded, dated, signed, and sent to the MTF QA committee.

8–2. Clinical director

The clinical director—

a. Carries out the QAP within the CCC by developing, implementing, and monitoring the QA activities with assistance from the clinical consultant and the MEDCEN or MEDDAC QAC.

b. Ensures that all responsible clinical staff are involved in the QAP and are knowledgeable and committed to QA objectives that relate to their specific areas of responsibility.

c. In coordination with the clinical consultant, determines the appropriate structure and membership of the CCC QA committee.

d. Chairs the CCC QA committee.

e. Defines areas of responsibility and determines priorities in the QAP in order to provide consistency and eliminate overlap and duplication of efforts while complying with regulatory requirements.

f. Disseminates recommendations from the MTF QA committee to the CCC staff.

g. Refers problems that cannot be resolved within the CCC to the appropriate resource.

h. Ensures that a followup mechanism is established to provide responses to problems and recommendations.

8–3. CCC QA committee

The CCC QA committee—

a. Implements all QA activities identified in the QAP.

b. Reports pertinent QA findings to the MTF credentials committee through the clinical consultant.

c. Analyzes findings to determine patterns and trends.

8–4. Patient care evaluation

a. Monitoring and evaluation will be done per paragraph 3–2.

(1) Examples of high risk, high volume, problem prone, and high cost aspects of care common in drug and alcohol programs are as follows:

(a) High risk.

1. Concurrent depression and/or suicidal ideation.

2. History of violent behavior when intoxicated.

3. Subject to Personnel Reliability Program.

4. Single, alcoholic males over 40 years of age.

(b) High volume.

1. Polydrug abusers.

2. Deliberate abuse—no dependency.

3. Early stage alcoholics.

(c) Problem prone.

1. Recidivists.

2. Patients who fail to progress.

3. Patients with performance or behavior problems.

(d) High cost. Inpatient versus outpatient treatment.

(2) Specific indicators will be developed. Once developed, they should be prioritized. The number of indicators selected for monitoring will be the number the staff can reasonably monitor and evaluate. Criteria will be developed for each indicator (para 3–2) and the care given compared against these criteria. Variations from these criteria are not a measure of quality but should trigger the peer review process. If a problem exists, it will be documented and corrective actions will be taken. (See para 3–2*h* and*i*.)

b. Patient records review (para 3–3*a*(5)).

(1) Records will be reviewed for their accuracy, timeliness, completeness, clinical pertinence, and adequacy as medicolegal documents.

(2) Indicators with criteria will be developed for record review.

(3) Each counselor will ensure that results of each review with recommendations are sent to the clinical director for summary analysis and reporting to the CCC QA committee.

(4) Identified problems require corrective action and followup. The accession log will be used; however, numbers will be used instead of names.

(5) Record deficiencies will be put in writing and forwarded through the clinical director to the appropriate staff members.

c. At a minimum, 10 percent of the active patient records, to include a representative sample of cases from each counselor, will be reviewed. Results will be forwarded to the clinical director and presented at monthly meetings. The clinical director, counselor supervisors, and clinical consultant (if possible) should be present at these meetings to provide clinical supervision and consultation.

8–5. Utilization management

An ongoing evaluation of clinical resource management will be utilized to assure that quality patient care is provided in the most cost-effective manner.

a. For components of a utilization management plan, see paragraph 3–4*a*.

b. Examples of indicators to determine efficient utilization of resources are as follows:

(1) Appropriateness of entry into the ADAPCP program.

(2) Missed appointments.

(3) Analysis of services rendered (ADAPCP statistics).

(4) Appropriateness of referrals.

(5) Delays in provision of supportive services.

(6) Administrative impacts (adequacy, distribution, availability, and use of resources to include space, personnel, supplies, and equipment).

(7) Comparison of a sampling of cases against length-of-treatment norms.

c. Utilization management issues will be addressed at each monthly QA staff meeting and included as part of the CCC QA committee minutes reported to the MTF QA committee.

d. The utilization management plan will be evaluated annually

and revised as appropriate. The length-of-treatment norms will be revised based on the previous 3 year's data.

8–6. Risk management

a. RM includes all activities concerned with accident and injury prevention and the lowering of financial losses after an injury has occurred.It identifies problems or potential risk circumstances that must be eliminated or reduced to prevent accident and injury.

b. One CCC staff member will be designated as risk manager. (There is no requirement for a separate RM committee.) The risk manager is responsible for tracking RM issues, identifying RM trends, reporting to the CCC QA committee at least quarterly, and assuring that RM issues are forwarded to the MTF risk manager.

c. It is the responsibility of each staff member involved in, or having knowledge of, an unusual occurrence or incident (including adverse responses to treatments and approaches or serious errors in clinical judgments), to prepare a DA Form 4106 (para 3–5*b*(3)) and report it to the risk manager through his or her supervisor. (The clinical director will ensure appropriate action and followup.)

d. The following are examples of potential RM issues, the more serious of which can be identified by an RM occurrence screening tool:

(1) All unusual occurrence reports.
(2) Adverse treatment results.
(3) Treatment failures.
(4) Patient complaints.
(5) Safety practices.
(6) Alcohol and drug related injuries.
(7) Cases of delayed treatment or failure to treat.

e. Cases reviewed will be documented.

f. A summary of RM activities and cases reviewed will be reported to the MTF QA committee. This summary will be documented in the RM portion of the CCC QA committee minutes. Major or serious problems will be reported immediately.

8–7. Privileging

a. Professional staff who function independently to initiate, alter, or terminate a regimen of medical care will be privileged. Professional staff who function under the supervision of the clinical director and all counselors who function under the supervision of a credentialed provider will not be granted individual privileges. Rather, an internal mechanism will be established to ensure that all staff members are competent to provide clinical services by reason of education, training, and experience.

b. The clinical director will be granted privileges by the MTF credentials committee. All directors should be physically and emotionally able to perform the duties required and must be free of substance abuse.

(1) Given the significant variability that can exist in the educational and experiential backgrounds of clinical directors, it will be necessary to define the category of privileges to include levels of supervision and consultation requirements.

(2) It is recognized that the number of adolescent patients enrolled in the ADAPCP will be at a minimal level. Therefore, lack of qualifications in this area will not be the sole limiting criteria for privileging where appropriate referral agencies are available.

c. The clinical consultant will attend the MTF credentials committee meeting when the privileges of the clinical director are being considered. Privileges will be based on education, training, experience, and current competency. DA Forms 5440–22–R and 5441–22–R will be used.

d. The following will be used as guidelines in the granting of clinical privileges for the Psychology (GS–180) series:

(1) *Category I.* Limited privileges for patient care within the field of substance abuse for adolescents and adults. Supervision or consultation will be required for all complex cases. The individual can act independently in directing patient care subject to review. He or she must have satisfactory completion of a bachelor's or master's degree including 24 semester hours in psychology and at least 1 year of full-time equivalent psychology experience in treating substance abuse in adults.

(2) *Category II.* Privileges for patient care within the field of substance abuse for adolescents and adults. Supervision or consultation will be necessary for all complex cases. The individual can act independently in directing patient care subject to review. He or she must have satisfactory completion of 2 full years of postgraduate study or a master's degree in counseling psychology, or a directly related field from an accredited educational institution, or the following:

(a) Satisfactory completion of a 4-year baccalaureate program with at least 24 semester hours in psychology.

(b) Two years of full-time equivalent professional psychology experience in treating substance abuse in adults.

(3) *Category III.* Full privileges for patient care within the field of substance abuse for adults and limited privileges for adolescents. Supervision or consultation will be necessary for all complex adolescent cases. The individual may act independently in directing patient care subject to review. He or she must have satisfactory completion of all the requirements for a doctoral degree in clinical or counseling psychology, or a directly related field from an accredited educational institution, or the following:

(a) Satisfactory completion of 2 full years of postgraduate study or a master's degree in counseling psychology, or a directly related field from an accredited educational institution.

(b) One year full-time equivalent professional experience in an operating substance abuse program treating adults.

(4) *Category IV.* Full privileges for patient care as a clinical director within the field of substance abuse for adolescents and adults. The individual may act independently in directing patient care. He or she will have satisfactory completion of all the requirements for a doctoral degree in clinical or counseling psychology or a directly related field from an accredited educational institution, and 1 year full-time equivalent professional psychology experience in treating substance abuse in adolescents; or each of the following:

(a) Satisfactory completion of 2 full years of postgraduate study or a master's degree in counseling psychology or a directly related field from an accredited educational institution.

(b) One year full-time equivalent experience in an operating substance abuse program treating adults.

(c) One year full-time equivalent professional psychology experience in treating substance abuse in adolescents.

e. The following will be used as guidelines in the granting of clinical privileges for the Social Worker (GS–185) series:

(1) *Category I.* Limited privileges for patient care within the field of substance abuse for adolescents and adults. Supervision or consultation will be required for all complex cases. The individual must have completed formal training at the master's degree level in social work and have a minimum of 1 year's supervised professional social work experience. The individual can act independently in directing patient care subject to review.

(2) *Category II.* Privileges for patient care within the field of substance abuse for adults and limited privileges for adolescents. Supervision or consultation will be required for all complex cases. The individual can act independently in directing patient care subject to review. The individual must have completed formal training at the master's or doctoral level in social work and have 2 year's supervised professional social work experience, or the following:

(a) Have completed formal training at the master's degree level in social work and have a minimum of 1 year's supervised professional social work experience.

(b) One year's supervisory experience in a drug and alcohol setting.

(3) *Category III.* Full privileges for patient care within the field of substance abuse for adults and limited privileges for adolescents. Supervision or consultation will be necessary for all complex adolescent cases. The individual may act independently in directing patient care subject to review. The individual must have completed formal training at the master's or doctoral level in social work, and—

(a) Have 2 year's supervised professional social work experience.

(b) Have 1 year's full-time supervisory experience in a drug and alcohol setting.

(4) *Category IV.* Full privileges for patient care as a clinical director within the field of substance abuse for adolescents and adults. The individual may act independently in directing patient care subject to review. He or she must have completed formal training at the master's or doctoral level in social work, and—

(a) Have 2 years of supervised professional social work experience.

(b) One year of professional experience in substance abuse counseling in adolescents (may have been acquired during the supervised period mentioned above).

f. Privileges for clinical directors in the GS–101 social science series will be granted on a case-by-case basis, dependent on formal education, current competency, and supervisory experience in a drug and alcohol setting.

g. A PCF and PAF will be maintained by the MTF credentials committee on all privileged individuals per paragraphs 4–11 and 4–12.

Chapter 9
Professional Licensure

9–1. Policy

a. Active duty, RC, and civilian employee (Federal civil service, foreign national hire, or contract) physicians, dentists, nurses (registered, practical, or vocational), clinical psychologists, podiatrists, optometrists, pharmacists, physical therapists, and dental hygienists will maintain a valid, current professional license that meets the following criteria:

(1) The license must be one granted by the recognized licensing agency of a State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

(a) Graduates of foreign medical schools will be required to possess both a medical license and other certification by the ECFMG or 5th Pathway.

(b) Foreign national hires in oversea areas may use a current, valid license from the country in which they are practicing.

(c) Nurses are required to pass the examination offered by the National Council for Licensure Examinations (NCLEX) before working without supervision.

(2) For active duty military, a valid, current license includes licenses with no fee or reduced fee schedules for military personnel where the issuing authority maintains and considers current information on individuals so licensed.

b. The requirements of this chapter also apply to those who are not classifiable as employees of the Army but are providing patient care services in an Army MTF or DTF.

c. Personnel required to be licensed by this regulation, who were not previously required to possess a license, must possess a license by 8 November 1988 unless a later date is prescribed.

d. Military and civilian optometrists, podiatrists, pharmacists, physical therapists, and dental hygienists must possess a license by 31 July 1989. Active duty practical nurses in enlisted ranks must possess a license by 8 November 1990.

e. Personnel in GHPE will not be required to possess a license until 1 year following successful completion of either the first year or the second year of such training, depending on the requirements of the State in which the individual will be licensed.

(1) Individuals indicating that they are seeking licensure in States requiring 2 years of training will provide evidence of legal residence in that State; for example, a Leave and Earnings Statement.

(2) If a State issues a graduate education license, it will be considered adequate for individuals in GHPE but will necessitate delay in progressing to independent responsibility following completion of training.

f. HCPs must apply for licensure within 30 days of obtaining notification of having successfully passed a qualifying examination.

g. HCPs who enter the Armed Forces immediately after training and do not enter a GHPE program and do not have a current, active license will not be eligible to provide patient care services independently. They will work only in supervised positions under a licensed professional of the same or similar discipline and will obtain a current, active license within 1 year of eligibility.

h. Unlicensed physicians and dentists assigned to TOE units immediately after the 1st or 2d year of GHPE and not privileged to practice within a hospital setting will be allowed to provide health care independently for 1 year.

(1) Those individuals not possessing a current, valid license by 1 year will not be allowed to continue providing health care independently.

(2) Those individuals assigned to other than TOE units as general medical officers or general dental officers are required to have a license in order to practice independently. Evidence of licensure will be provided to the major medical command exercising professional or technical control. Those individuals with no clearly defined medical channels will provide such evidence to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

i. Newly employed foreign national physicians will be allowed to practice under supervision for up to 1 year during which time information on which a waiver may be based will be obtained (*l*(3) below). The waiver must be approved prior to the end of the probationary appointment.

j. Foreign national physicians must posses either ECFMG certification or a license from the country in which they are practicing.

k. Failure to obtain a license may constitute reason to institute adverse personnel actions, including loss of professional pays and separation from the service, unless specifically waived by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)).

(1) Practice privileges of practitioners failing to obtain licenses will be restricted to reflect that they are prohibited from providing patient care services unless under the supervision of a health care professional of the same or similar discipline (as determined by the commander). Restriction of privileges will be performed by the credentials committee and reported per paragraph 4–9*k*. The supervisor, appointed in writing, will be responsible for the care provided by the unlicensed practitioner.

(2) Practitioners not subject to the UCMJ who provide health care in violation of this restriction are subject to a civil money penalty of not more than $5,000 (10 USC 1094). (Military HCPs are subject to penalties under the UCMJ.)

l. Circumstances that may be given favorable consideration for waiver are as follows:

(1) Active duty military personnel stationed overseas or in remote sites at any time during the period between 18 July 1985 and 8 November 1988 may apply to OTSG for a temporary license waiver until 1 year following their return to continental United States (CONUS). Waivers will be considered by the individual's command on a case by case basis. Extensions of overseas tours to avoid licensure requirements will not be permitted.

(2) HCPs coming directly from education programs in professions requiring a period of practice experience prior to licensure will be permitted to practice, under supervision, during the required period. Failure to obtain a license at the end of the mandatory period of practice may constitute reason to institute adverse personnel action and/or separation proceedings.

(3) Physicians and dentists not possessing U.S. licenses nor practicing in the United States or its territories will be required to document proof of English competency and clinical skills. One or more of the following in addition to the individual's PCF, including current DA Forms 5374–R and 5441–R-series, will be submitted for waiver consideration:

(a) Certification by the ECFMG.

(b) Successful completion of the examination offered by the Uniformed Services University of the Health Sciences.

(c) Objective assessment of performance through explicit clinical monitoring from a functioning QAP. Also addressed will be the practitioner's proficiency level, past performance, and continuing education.

(4) Waiver requests will be sent through command channels to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. TSG's evaluation and recommendation will be forwarded to ASD(HA) for waiver determination.

m. The following apply only to military personnel:

(1) All individuals who are not in compliance with this chapter will have all favorable personnel actions suspended under AR 600–8–2.

(2) As a general policy those individuals who are not in compliance with this chapter and are in an obligated status, as defined in the glossary, will be used in their specialties under the supervision of appropriately licensed health care personnel or in such capacities as their commander may direct until the expiration of their obligations. At that time they will be eliminated from the service under the provisions of AR 635–100 or AR 135–175 for loss of professional qualifications.

(a) Being in an obligated status does not preclude earlier elimination from the service for loss of professional qualifications or for other reasons should competent authority determine this to be in the best interest of the service.

(b) Those individuals who are eliminated prior to completion of obligated service may be subject to recoupment of educational subsidies.

(3) Those individuals who are not in compliance with this paragraph and who have no current service obligation may be eliminated from the service under the provisions of AR 635–100 or AR 135–175 for loss of professional qualifications or for such other reasons appropriate to the individual case.

(4) Obligations resulting from acceptance of special incentive pays, military education (advanced course, and so forth), acceptance of promotion, or resulting from the 3-year initial active duty obligation incurred upon accession without service sponsored education will be handled under (2) above. Entitlement to and recoupment of incentive pays will be determined by the appropriate finance office.

n. The Office of Personnel Management (OPM) has established the minimum qualification requirements for each classification series by grade level in its OPM Handbook (Hdbk) X–118. For AMEDD civil service positions wherever an OPM Hdbk X–118 or DOD requirement exists for a specific license, registration, or certification as a condition of eligibility for a position, maintenance of that requirement is a condition of employment.

o. Licensure requirements apply regardless of whether the individuals are performing clinical or administrative duties. Individuals not assigned to or privileged by a MEDDAC, MEDCEN, or DENTAC will provide evidence of current licensure to the major medical command exercising professional or technical control.

9–2. Payment of fees associated with professional licensure

Appropriated funds will not be used to pay the expenses for obtaining and maintaining a professional license. Permissive TDY (travel orders which show no entitlement to per diem or travel or lodging expenses) may be granted for the purpose of taking licensure examinations or for appearing for interviews required by the licensing agency as a condition for granting a license. Leave will not be charged for this purpose unless the individual already has a license that meets the requirements of this regulation.

Appendix A
References

Section I
Related Publications

AR 15–6
Procedure for Investigating Officers and Boards of Officers.

AR 20–1
Inspector General Activities and Procedures.

AR 25–400–2
The Modern Army Recordkeeping System (MARKS).

AR 27–20
Claims.

AR 27–40
Litigation.

AR 40–1
Composition, Mission, and Functions of the Army Medical Department.

AR 40–2
Army Medical Treatment Facilities: General Administration.

AR 40–3
Medical, Dental, and Veterinary Care.

AR 40–5
Preventive Medicine.

AR 40–6
Army Nurse Corps.

AR 40–48
Nonphysician Health Care Providers.

AR 40–61
Medical Logistics Policies and Procedures.

AR 40–66
Medical Record and Quality Assurance Administration.

AR 40–407
Nursing Records and Reports.

AR 135–175
Separation of Officers.

AR 340–21
The Army Privacy Program.

AR 351–3
Professional Education and Training Programs of the Army Medical Department.

AR 600–8–2
Suspension of Favorable Personnel Actions (Flags).

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program.

AR 611–201
Enlisted Career Management Fields and Military Occupational Specialties.

AR 614–5
Stabilization of Tours.

AR 635–100
Officer Personnel.

AR 635–200
Enlisted Personnel.

DA Pam 40–5
Army Medical Department Standards of Nursing Practice.

DA Pam 40–16
Dental Statistical Reporting.

Diagnostic and Statistical Manual III
(This publication may be obtained from The American Psychiatric Association, 1700 18th Street, N.W., Washington, DC 20009.)

FM 8–70/AFR 160–24/NAVMED P–5120
Standards for Blood Banks and Transfusion Services.

FPM
Federal Personnel Manual, U.S. Civil Service Commission (chaps 315 and 432).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Publications:
Accreditation Manual for Hospitals.
Ambulatory Care Manual.
Drug and Alcohol Facilities Manual.
Hospital Accreditation Program Scoring Guidelines: Nursing Services, Infection Control, Special Care Units.
Monitoring and Evaluation of Nursing Services.
Psychiatric Services Manual.
(The current editions of the six publications listed above may be obtained from JCAHO, 875 N. Michigan Avenue., Chicago, IL 60611.)

Occupational Therapy Quality Assurance Handbook.
(This publication may be obtained from HQDA (DASG–DB), 5109 Leesburg Pike, Falls Church, VA 22041–3258.)

OPM Hdbk X–118
Qualification Standards for Positions Under the General Schedule.

Physical Therapy Quality Assurance Handbook.
(This publication may be obtained from HQDA (DASG–DB), 5109 Leesburg Pike, Falls Church, VA 22041–3258.)

TB MED 521
Management and Control of Diagnostic X-Ray, Therapeutic X-Ray, and Gamma-Beam Equipment.

TB MED 530
Occupational and Environmental Health Food Service Sanitation.

UCMJ
Manual for Courts-martial, United States 1984.

Section II
Prescribed Forms

DA Form 4106
Quality Assurance/Risk Management Document. (Prescribed in para 3–5*b*.)

DA Form 4691–R
Initial Application for Clinical Privileges. (Prescribed in para 4–8*a*(1).)

DA Form 5374–R
Performance Assessment. (Prescribed in para 4–8*e*(1).)

DA Form 5440–R
Delineation of Privileges—Anesthesia. (Prescribed in para 4–8*a*(1).)

DA Form 5440A–R
Delineation of Privileges Record. (Prescribed in para 4–8*a*(1).)

DA Form 5440–1–R
Delineation of Privileges—Dentistry. (Prescribed in para 4–8*a*(1).)

DA Form 5440–2–R
Delineation of Privileges—Family Practice. (Prescribed in para 4–8*a*(1).)

DA Form 5440–3–R
Delineation of Privileges—Internal Medicine and Subspecialty.(Prescribed in para 4–8*a*(1).)

DA Form 5440–4–R
Delineation of Privileges—Neurology. (Prescribed in para 4–8*a*(1).)

DA Form 5440–5–R
Delineation of Privileges—Obstetrics and Gynecology. (Prescribed in para 4–8*a*(1).)

DA Form 5440–6–R
Delineation of Privileges—Optometry Service. (Prescribed in para 4–8*a*(1).)

DA Form 5440–7–R
Delineation of Privileges—Pathology. (Prescribed in para 4–8*a*(1).)

DA Form 5440–8–R
Delineation of Privileges—Pediatrics. (Prescribed in para 4–8*a*(1).)

DA Form 5440–9–R
Delineation of Privileges—Podiatry. (Prescribed in para 4–8*a*(1).)

DA Form 5440–10–R
Delineation of Privileges—Psychiatry. (Prescribed in para 4–8*a*(1).)

DA Form 5440–11–R
Delineation of Privileges—Psychology. (Prescribed in para 4–8*a*(1).)

DA Form 5440–12–R
Delineation of Privileges—Radiology/Nuclear Medicine. (Prescribed in para 4–8*a*(1).)

DA Form 5440–13–R
Delineation of Privileges—Surgery. (Prescribed in para 4–8*a*(1).)

DA Form 5440–14–R
Delineation of Privileges—Nurse Anesthetists. (Prescribed in para 4–8*a*(1).)

DA Form 5440–15–R
Delineation of Privileges—Nurse Midwives. (Prescribed in para 4–8*a*(1).)

DA Form 5440–16–R
Delineation of Privileges—Nurse Practitioners (Adult).(Prescribed in para 4–8*a*(1).)

DA Form 5440–17–R
Delineation of Privileges—OB/GYN Nurse Practitioner. (Prescribed in para 4–8*a*(1).)

DA Form 5440–18–R
Delineation of Privileges—Physician Assistants. (Prescribed in para 4–8*a*(1).)

DA Form 5440–19–R
Delineation of Privileges—Dietetics. (Prescribed in para 4–8*a*(1).)

DA Form 5440–20–R
Delineation of Privileges—Occupational Therapy. (Prescribed in para 4–8*a*(1).)

DA Form 5440–21–R
Delineation of Privileges—Physical Therapy. (Prescribed in para 4–8*a*(1).)

DA Form 5440–22–R
Delineation of Privileges. (Prescribed in para 4–8*d*.)

DA Form 5440–23–R
Delineation of Privileges—Emergency Medicine. (Prescribed in para 4–8*a*(1).)

DA Form 5440–24–R
Delineation of Privileges—Aviation Medicine. (Prescribed in para 4–8*a*(1).)

DA Form 5440–25–R
Delineation of Privileges—General Medical Officer. (Prescribed in para 4–8*a*(1).)

DA Form 5440–26–1–R
Delineation of Privileges—Troop Medical Clinic Physicians. (Prescribed in para 4–8*a*(1).)

DA Form 5440–26–2–R
Delineation of Privileges—Troop Medical Clinic Dentists. (Prescribed in para 4–8*a*(1).)

DA Form 5440–26–3–R
Delineation of Privileges—Troop Medical Clinic Physician Assistants. (Prescribed in para 4–8*a*(1).)

DA Form 5441–R
Evaluation of Privileges—Anesthesia. (Prescribed in para 4–8*e*(1).)

DA Form 5441–1–R
Evaluation of Privileges—Dentistry. (Prescribed in para 4–8*e*(1).)

DA Form 5441–2–R
Evaluation of Privileges—Family Practice. (Prescribed in para 4–8*e*(1).)

DA Form 5441–3–R
Evaluation of Privileges—Internal Medicine and Subspecialty. (Prescribed in para 4–8*e*(1).)

DA Form 5441–4–R
Evaluation of Privileges—Neurology. (Prescribed in para 4–8*e*(1).)

DA Form 5441–5–R
Evaluation of Privileges—Obstetrics and Gynecology. (Prescribed in para 4–8*e*(1).)

DA Form 5441–6–R
Evaluation of Privileges—Optometry Service. (Prescribed in para 4–8*e*(1).)

DA Form 5441–7–R
Evaluation of Privileges—Pathology. (Prescribed in para 4–8*e*(1).)

DA Form 5441–8–R
Evaluation of Privileges—Pediatrics. (Prescribed in para 4–8*e*(1).)

DA Form 5441–9–R
Evaluation of Privileges—Podiatry. (Prescribed in para 4–8*e*(1).)

DA Form 5441–10–R
Evaluation of Privileges—Psychiatry. (Prescribed in para 4–8*e*(1).)

DA Form 5441–11–R
Evaluation of Privileges—Psychology. (Prescribed in para 4–8*e*(1).)

DA Form 5441–12–R
Evaluation of Privileges—Radiology/Nuclear Medicine. (Prescribed in para 4–8*e*(1).)

DA Form 5441–13–R
Evaluation of Privileges—Surgery. (Prescribed in para 4–8*e*(1).)

DA Form 5441–14–R
Evaluation of Privileges—Nurse Anesthetists. (Prescribed in para 4–8*e*(1).)

DA Form 5441–15–R
Evaluation of Privileges—Nurse Midwives. (Prescribed in para 4–8*e*(1).)

DA Form 5441–16–R
Evaluation of Privileges—Nurse Practitioners (Adult). (Prescribed in para 4–8*e*(1).)

DA Form 5441–17–R
Evaluation of Privileges—OB/GYN Nurse Practitioner (Prescribed in para 4–8*e*(1).)

DA Form 5441–18–R
Evaluation of Privileges—Physician Assistants. (Prescribed in para 4–8*e*(1).)

DA Form 5441–19–R
Evaluation of Privileges—Dietitian. (Prescribed in para 4–8*e*(1).)

DA Form 5441–20–R
Evaluation of Privileges—Occupational Therapy. (Prescribed in para 4–8*e*(1).)

DA Form 5441–21–R
Evaluation of Privileges—Physical Therapy. (Prescribed in para 4–8*e*(1).)

DA Form 5441–22–R
Evaluation of Privileges. (See the DA Form 5440–22–R entry and para 4–8*d* for completion of this form.) (Prescribed in para 4–8*e*(1).)

DA Form 5441–23–R
Evaluation of Privileges—Emergency Medicine. (Prescribed in para 4–8*e*(1).)

DA Form 5441–24–R
Evaluation of Privileges—Aviation Medicine. (Prescribed in para 4–8*e*(1).)

DA Form 5441–25–R
Evaluation of Privileges—General Medical Officer. (Prescribed in para 4–8*e*(1).)

DA Form 5441–26–1–R
Evaluation of Privileges—Troop Medical Clinic Physicians. (Prescribed in para 4–8*e*(1).)

DA Form 5441–26–2–R
Evaluation of Privileges—Troop Medical Clinic Dentists. (Prescribed in para 4–8*e*(1).)

DA Form 5441–26–3–R
Evaluation of Privileges—Troop Medical Clinic Physician Assistants. (Prescribed in para 4–8*e*(1).)

DA Form 5753–R
USAR or ARNG Application for Clinical Privileges to Perform Active or Inactive Duty Training. (Prescribed in para 6–2*c*.)

DA Form 5754–R
Malpractice and Privileges Questionnaire. (Prescribed in para B–3*a*.)

DD Form 2499
Health Care Provider Adverse Clinical Privileges Action Report(Requirement Control Symbol DD–HH(AR) 1611). (Prescribed in para 4–9*k*.) (This form is stocked and issued from HQDA (SGPS–PSQ) 5109 Leesburg Pike, Falls Church, VA 22041–3258.)

Section III
Referenced Forms

DA Form 71
Oath of Office—Military Personnel.

DA Form 751 (Obsolete, see OF 271.)
Telephone or Verbal Conversation. (Will be used until stock is exhausted.)

DA Form 3881
Rights Warning Procedure/Waiver Certificate.

DA Form 4692–R
Clinical Privileges Annual Evaluation. (This form is obsolete but, if previously completed, it will be kept for historical purposes in individual files.)

DA Form 4700
Medical Record—Supplemental Medical Data.

OF 271
Conversation Record. (DA Form 751 will be used until stock is exhausted.)

SF 509
Medical Record—Doctor's Progress Notes.

SF 513
Medical Record—Consultation Sheet.

SF 600
Health Record—Chronological Record of Medical Care.

SF 603
Health Record—Dental.

SF 603A
Health Record—Dental Continuation.

Appendix B
Preselection Procedures for Nonmilitary Health Care Personnel

B–1. General

a. Covered health care personnel and activities. This appendix applies to servicing CPOs, procurement offices, and commanders or directors of AMEDD activities. Its provisions cover personnel in the following occupations and their equivalents in foreign national local hire and contract positions: Medical Officer, GS–0602; Dentist, GS–0680; Veterinarian, GS–0701; Nurse GS–0610; Podiatrist, GS–0660; Physician Assistant, GS–0603; Clinical Psychologist, GS–0180; Optometrist, GS–0662; Physical Therapist, GS–0633; Occupational Therapist, GS–0631; Social Worker, GS–0185; Dietitian, GS–0630; Pharmacist, GS–0660; Speech Pathologist, GS–0665;

Psychologist, GS–0180; Audiologist, GS–0663; Medical Technologist, GS–0644; Emergency Medical Technician, GS–0699; Paramedic, GS–0699; Licensed Practical Nurse, GS–0620; and Dental Hygienist, GS–0682.

b. Preselection verification. Preselection verification of education, training, clinical experience, licensure, and certification or registration before appointment and/or placement into selected civil service, consultant and expert, contracted, and foreign national local hire positions is required. This includes any movement into positions or functions defined in *a* above. For internal placement, a modified verification procedure may be accomplished as long as the cumulative result is comparable to the requirements defined herein.

B–2. Preselection tasks

a. For Civil Service, consultants and experts, and foreign national local hires, the servicing CPO and employing AMEDD activity perform data collection.

b. For contracted services, the contracting office provides for data collection (see para B–4).

c. The AMEDD activity commander or director ultimately performs the preselection validation or verification including resolution of medical issues. Appointments to these AMEDD positions may only be made after receipt of the AMEDD commander or director's (or designee's) written certification of the acceptability of the candidate.

B–3. Procedures for civil service, consultant and expert, and foreign national local hires

a. Candidate or applicant. The applicant will submit DA Form 4691–R, DA Form 5754–R (Malpractice and Privileges Questionnaire), and at least two letters of reference. (DA Form 5754–R will be reproduced locally, head to head, on 8½- by 11-inch paper; a copy for reproduction is located at the back of this regulation.) The reference letters will be mailed directly to the CPO staffing specialist from the author. The letters will be from the following, as appropriate:

(1) One from the chief of staff, hospital or clinic administrator, professional supervisor, or department chairperson of the applicant's hospital.

(2) Director or faculty member of the applicant's training program, if the applicant has been in a training program within the past 5 years.

(3) A health care professional of his or her discipline in a position to evaluate the applicant's professional standing, abilities, and character (for example, a peer or a president or secretary of the local professional society). Both peer and professional association or society assessment (if a member) are mandatory if self-employed.

b. Servicing CPO. A CPO official will—

(1) Obtain certified copies of the following from the applicant:

(a) Qualifying education (transcript and diploma) and board certification, as applicable.

(b) Applicant's license(s), registration, or certification, as applicable.

(c) Certifications of completed continuing education, as applicable, along with the category type. This information must cover 3 years, or from the time the applicant obtained the qualifying degree, if less than 3 years.

(d) For the non-United States and non-Canadian trained physician, his or her ECFMG certificate.

(2) Voucher medical facilities and institutions where the applicant was educated and/or employed.

(3) Have the applicant secure at least two letters of reference. (See *a* above.)

(4) Collect, organize, and send all information and data to the AMEDD facility action office.

c. AMEDD facility. A MEDDAC, MEDCEN, or DENTAC staff member will—

(1) Contact HQDA (SGPS–PSQ) (AUTOVON 289–0088; commercial (703)756–0088) for verification of education, training, licensure, registration, or certification, as necessary.

(2) Determine if any of the applicant's licenses or registrations have been or are currently being challenged; whether the applicant has been involved in any adverse malpractice actions, and whether he or she has experienced a loss of medical organization membership, clinical privileges, or membership at any other hospital.

(3) Verify Drug Enforcement Agency (DEA) status.

(4) Obtain and verify a history of clinical privileges performed, as applicable.

(5) Complete the selection process to include documentation of actions and return of the completed package to the CPO.

(6) Record any verification by telephone communication between the facility and HQDA (SGPS–PSQ) on the document itself and on official letterhead, which are signed and dated by the individual making the call. These letters will be placed in section VI of the PCF.

(7) Contact HQDA (SGPS–PSQ) per *c* above if the medical diploma has been issued by a foreign medical school in a country that has no diplomatic relations with the United States.

B–4. Contracted services

The contracting office will have accomplished the preselection verification (para B–1*b*) and will provide adequate proof of it upon request by the AMEDD activity.

Appendix C
MTF Department of Nursing Quality Assurance Program

C–1. Overview

The MTF nursing QAP provides for a planned, systematic, ongoing process to monitor, evaluate, and document the quality and appropriateness of nursing care and clinical nursing practice; and to identify and pursue opportunities to improve patient care and effect problem resolution. The nursing QAP applies to all nursing personnel practicing in inpatient and ambulatory settings.

C–2. Goals

The nursing QAP will—

a. Provide the framework for the development, implementation, and evaluation of nursing QA processes.

b. Include at least the following as goals at each MTF:

(1) Implementation and use of standards of nursing care, practice, and performance to establish the acceptable level of clinical care based upon the resources available.

(2) Development of a planned, systematic, ongoing mechanism for monitoring and evaluating clinical performance and the delivery of patient care.

(3) Development of a mechanism for corrective action, followup and reevaluation when opportunities to improve care and resolve problems are identified.

(4) Integration of department of nursing QA objectives with the MTF QAP.

c. Include any additional goals as required by the MTF mission.

C–3. Procedures

a. The chief, department of nursing, maintains the overall responsibility for an ongoing nursing QAP for the MTF.

b. The chief, department of nursing, will appoint a QA nurse who will coordinate, implement, and monitor the nursing QAP.

c. All department of nursing personnel will implement the nursing QAP at their respective levels.

C–4. Organization and structure

Each MTF will have a unit-based nursing QAP with central oversight and direction provided by the chief, department of nursing, through a nursing QA committee (see para 2–2) and a QA nurse.

a. The department of nursing QA committee, with the assistance of the QA nurse, will—

(1) Have representation from each nursing element to include:

inpatient units, operating room, central materiel, infection control nursing, nursing education and staff development, anesthesia nursing, ambulatory nursing, community health nursing, occupational health nursing, and any others as determined by the chief, department of nursing, per the MTF QAP.

(2) Facilitate and coordinate the uniform and systematic collection, analysis, and use of information.

(3) Report activities and information to the MTF QA committee as indicated.

b. Each nursing element will develop and implement a written QA plan that provides for the overall integration of its nursing QA activities into the department of nursing QAP.

c. Nursing QA activities will be coordinated with other MTF organizational elements to resolve problems and improve care at the most appropriate level.

C–5. Components

The four major aspects of the nursing QAP are patient care assessment, competence, risk management, and utilization management. Integration of these elements within the program assures a comprehensive, broad-spectrum approach to identifying deficiencies and opportunities for improvement in nursing care.

a. Patient care assessment. This process evaluates the quality and appropriateness of patient care, derived from standards of care, standards of practice, and other data sources.

(1) *Standards of care.* The following standards of care are the minimum standards for every patient. Additional standards may be developed at the unit level.

(a) Patient safety. All patients will be free from harm related to nursing practice or procedure variance.

(b) Patient education. All patients and significant others will receive education to enable them to restore, maintain, or promote health or function.

(c) The nursing process. All patients will have an individualized nursing plan of care, to include discharge planning.

(2) *Standards of practice.* Registered nurses are responsible for adherence to standards of practice as outlined in DA Pam 40–5 and, as appropriate, professional and/or specialty nursing organization standards.

(3) *Monitoring and evaluation.* The process described in paragraph 3–2 will be followed in patient care assessment. Results of the department's monitoring and evaluation activities will be communicated according to requirements outlined in paragraph C–6.

b. Competence.

(1) *Licensure.*

(a) All registered nurses will maintain a valid, current professional license with a stated expiration date.

(b) All licensed practical or vocational nurses will maintain a valid current license with a stated expiration date.

(c) There will be a method for verification and ongoing monitoring of current licensure.

(2) *Performance standards.* The clinical performance of all categories of nursing personnel practicing with the AMEDD will be evaluated based upon written job descriptions and standards of performance. The standards of performance will be criteria-based and periodically evaluated.

(3) *Knowledge and skills verification.* Mechanisms will be established to validate competency of all nursing personnel in the performance of nursing activities and tasks.

(4) *Clinical privileges.* Nursing personnel functioning as nonphysician HCPs will be granted clinical privileges in accordance with chapter 4.

(5) *Reporting.* Professional nurses and licensed practical nurses to whom any of the following apply will be reported through the next higher headquarters to HQDA (SGPS–PSQ), 5109 Leesburg Pike, Falls Church, VA 22041–3258. Licensing agencies will be notified by SGPS–PSQ as appropriate.

(a) Incompetent practice.

(b) Verbal or physical abuse of patient.

(c) Violation of confidentiality.

(d) Alcohol, drug, or psychological impairment.

(e) Falsification of records.

(f) Pleas of guilty or nolo contendere or conviction on criminal charges.

(g) Resignation or discharge in lieu of court-martial. Instances of *(a)* through *(g)* above will be reported upon discovery and initiation of actions, in the same manner as described for practitioners in paragraph 4–9*k*(1). In case of a serious incident involving any of the above, a telephonic report should be made per paragraph 4–9*b*(2), and a QA investigation may be indicated.

c. Risk management. At a minimum, the following nursing risk management issues will be addressed:

(1) Elopement or against-medical-advice events.

(2) Environmental safety.

(3) High risk circumstance identification.

(4) Medical materiel.

(5) Patient satisfaction.

(6) Practice and procedure variances.

(7) Unusual occurrence report analysis.

d. Utilization management. At a minimum, there will be a plan that provides for appropriate identification, allocation, and ongoing evaluation of personnel, financial, and equipment resources. Resources aspects of the workload management system for nurses, education expenditures, and nonstandard equipment items are examples of appropriate issues to be examined. At least the following continuity of care issues will also be addressed:

(1) Discharge planning.

(2) Patient education.

(3) Nursing care effects on length of stay.

C–6. Reporting requirements and mechanisms

a. Pertinent information from unit-based nursing QA activities will be documented and forwarded to the department of nursing QA committee through channels established by the department of nursing QA plan.

b. Information from the department of nursing QA committee will be disseminated throughout the department of nursing per procedures prescribed by the chief, department of nursing.

c. Information from the department of nursing QA committee will be reported by minutes to the MTF QA committee as per paragraph 2–2 and the MTF QAP.

d. Conclusions; recommendations; action; evaluation (CRAE) format will be used in reporting all nursing QA activities and identified opportunities to improve patient care:

(1) Conclusions.

(2) Recommendations.

(3) Actions taken.

(4) Evaluation and/or followup.

e. Medical confidentiality for all patients will be protected as fully as possible in all QA documentation.

f. Reports will be maintained at the MTF as prescribed in paragraph 2–2*c*.

g. A copy of all nursing QA forms will be sent to the respective major MEDCOM QA nurse consultant who will maintain a library of these forms for reference and future standardization purposes.

C–7. Evaluation of the MTF nursing QAP

a. The evaluation of nursing QA activities is intended to determine the effectiveness of the unit-based departmental program. The scope, objectives, organization, and effectiveness of the department QA plan will be evaluated at least annually and revised as necessary.

b. Evaluation of the nursing QAP by the chief, department of nursing, and the department of nursing QA committee will include—

(1) Comparison of the written plan with the nursing QA activities that were performed.

(2) Determination of the effectiveness of the monitoring and evaluation process leading to problem resolution and improved patient care.

(3) Determination that nursing QA information was communicated accurately and to the appropriate persons, groups, and committees.

C–8. Nursing QAP references

The department of nursing QAP is based on the following references:

a. AR 40–1.
b. AR 40–5.
c. AR 40–6.
d. AR 40–48.
e. AR 40–61.
f. AR 40–66.
g. AR 40–407.
h. DA Pam 40–5.
i. Accreditation Manual for Hospitals (JCAHO).
j. Drug and Alcohol Facilities Manual (JCAHO).
k. Psychiatric Services Manual (JCAHO).
l. Monitoring and Evaluation of Nursing Services (JCAHO).
m. Ambulatory Care Manual (JCAHO).
n. Hospital Accreditation Program Scoring Guidelines: Nursing Services, Infection Control, Special Care Units (JCAHO).

Appendix D
Nutrition Care Division or Directorate

D–1. Policy

a. Army nutrition care programs will be administered by a qualified staff of registered military or civilian dietitians. QA monitoring, data collection, trend analysis, problem solving, and QA in educational programs are the responsibility of the entire chain of command within the Nutrition Care Division (NCD).

b. The chief, NCD, will establish the QA program to assure excellence in nutritional care. This program will encompass, but not be limited to, the use of established monitors and standing operating procedures (SOPs).

c. The quality and appropriateness of patient care services provided will be monitored and evaluated on an ongoing basis (para 3–2).

d. The QA activities will be coordinated with the MTF QAP.

e. Individual clinical privileges will be delineated for all registered dietitians given the authority and responsibility for making independent decisions to initiate or alter a regimen of treatment. Where full performance of a civilian dietitian's role requires the dietitian to be individually privileged, privileging is a condition of employment.

f. Findings from division or directorate QA activities will be integrated into the unit inservice training schedule.

g. When performing patient care activities, students and other trainees will receive direct supervision.

h. Dietetic intern documentation in patient charts will be cosigned by a registered dietitian.

D–2. Procedure

a. Division QA officer. The division QA officer will be an Army Medical Specialist Corps commissioned officer appointed by the chief of the NCD. In an MTF supported by a sole dietitian, he or she will be the QA officer. Duties of the QA officer include at least the following:

(1) Maintaining liaison with the MTF QA committee.

(2) Analyzing and distributing QA performance data within the nutrition care division.

(3) Planning the division QA meetings.

(4) Preparing division QA committee agendas, reports, and minutes.

b. Division QA committee. The division QA committee will consist of the chief, nutrition care; chief, clinical dietetics; chief, production and service; the division noncommission officer in charge (NCOIC), and the division QA officer. In an MTF supported by a sole dietitian, the committee will consist of the dietitian and senior noncommissioned officers or senior civilian staff from the production and service and clinical dietetics functions.

c. Performance standards.

(1) Division QA performance standards for monitoring criteria will be established by the division QA committee.

(2) Any aspect of nutrition care services that does not meet established criteria standards will be assigned to the action officer responsible for that service until substandard performance meets the established criteria standards. Problems so defined will be recorded on the division problem solving record during resolution and reevaluation.

(3) Data collected and problem resolution will be discussed at regular division QA meetings.

(4) Data collected will be used in the evaluation of personnel.

d. Patient care evaluation. SOPs and indicators, with established criteria, will be used in the following:

(1) Peer review of nutrition care information in the patient's medical record. Dietitians who have successfully completed a dietetic internship, but who have not yet passed registration examinations, will sign patient record entries with their names and the title graduate dietitian (GD). In sole dietitian MTFs, the medical record review may be accomplished as a peer review during regional QA visits by the regional MEDCEN's QA officer.

(2) Evaluation of the thoroughness of nutrition instruction for inpatients, ambulatory care personnel, and the military community.

(3) Assessment of food quality and accuracy in the delivery of prescribed diets to patients.

e. Credentials and privileging process.

(1) Credentials review includes validation of education, training, current registration, and current competency.

(2) DA Forms 5440–19–R and 5441–19–R will be completed for the privileged dietitian at least every 2 years (except ARNG and USAR). (See also para 4–8.)

(3) Documentation of specialized training and/or AOC designation in clinical dietetics must be obtained by dietitians before they will be granted the following clinical privileges:

(a) Prescribing vitamins, therapeutic nutritional supplements, or diets other than weight control and modifications in consistency.

(b) Ordering laboratory tests.

f. Infection control.

(1) The NCD will have SOPs addressing infection control in patient care areas and in food production and service (TB MED 530).

(2) Infection control procedures as defined by AR 40–5 and procedures approved by the MTF infection control officer will be incorporated into division training programs and division operations.

(3) Documented review and approval of the division infection control procedures will be done annually by the MTF infection control committee or infection control officer.

g. Records.

(1) Within HSC, QA findings including summaries of actions taken will be forwarded annually to Commander, U.S. Army Health Services Command: ATTN: HSCL–S, Fort Sam Houston, TX 78234–6000. Seventh MEDCOM and 18th MEDCOM dietetic staff officers will forward their QA findings on an annual basis to Chief, Dietitian Section, HQDA (DASG–DBD) 5109 Leesburg Pike, Falls Church, VA 22041–3258.

(2) QA data trend analysis, identified problems and actions, evidence of resolution, and recommendations will be given to the MTF QA committee on a semiannual basis per table 2–1. A record of these data will be simultaneously forwarded to the appropriate headquarters dietetic staff officer or consultant.

(3) Additional QA data requested by the MTF QA committee will be forwarded by the division QA officer.

Appendix E
Occupational Therapy and Physical Therapy Activities

E–1. Policy

a. The Army MTF occupational therapy (OT) and physical therapy (PT) programs will be provided by a qualified staff of certified occupational therapists and licensed physical therapists. Civilian employees will meet and maintain requirements established by the OPM and DOD.

b. The chief of OT and PT will establish the QAP to assure quality patient care (para 3–1*a*).

c. The quality and appropriateness of patient care services provided will be monitored and evaluated on an ongoing basis, using established monitors and generic screens (para 3–2).

d. Multidisciplinary audits are encouraged; that is, combined audits with supervising services such as physical medicine and rehabilitation where appropriate, psychiatry, and orthopedics, or with other professionals associated with patient treatment.

e. The QA activities will be coordinated with the MTF's QAP.

f. In no instance will clinical privileges be granted when the therapist is unqualified by education, training, or experience.

g. Inservice training should address findings from the QA activities.

h. Whenever performing patient care activities, students and other trainees will receive direct supervision on a daily basis.

E–2. OT procedures

a. Section QA coordinator. The section chief or appointed section QAC will monitor the OT QA activities. Duties include at least—

(1) Maintaining liaison with the MTF committee.

(2) Updating monitors and developing generic screens.

(3) Analyzing and distributing QA data within the OT section as appropriate.

(4) Preparing OT QA reports.

(5) Evaluating the section QAP on an ongoing basis and documenting the evaluation at least annually.

(6) Following guidance contained in the Occupational Therapy Quality Assurance Handbook.

b. Patient care evaluation.

(1) Patient care evaluation will consist of ongoing, concurrent audits of the quality and appropriateness of patient care and health promotion interventions.

(2) SOPs and protocols approved by the supervising physician will be reviewed and updated annually by the section chief or the section QAC to reflect patient care service delivery advancements and program modifications.

(3) Indicators that are monitored on an ongoing basis include the following:

(a) Appropriateness of audit screen.

(b) Presence of audit screen identification entries.

(c) Audit screen evaluation criteria.

(d) Capacity of the audit screen to cross-reference records.

(e) Documentation of program review.

c. Credentials review and privileging process.

(1) Credentials review includes validation of graduation from an accredited school, current certification, specialty training, and competence.

(2) Occupational therapists granted clinical privileges include those performing primary upper extremity neuromusculoskeletal evaluations (NMSEs). Physician review will be per AR 40–48.

(3) An occupational therapist with additional education and/or training when qualified may be privileged by the MEDDAC or MEDCEN commander.

(4) DA Forms 5440–20–R and 5441–20–R will be completed for each privileged occupational therapist at least every 2 years (except ARNG and USAR). See also paragraph 4–8*a* and *e*.

d. Utilization management.

(1) Ongoing utilization management monitors will be developed for implementation by designated QACs of OT sections.

(2) Monitors include physician review of treatment program protocols.

(3) Specific indicators monitored include—

(a) Timeliness and appropriateness of OT services.

(b) Service delivery policies.

(c) Time from receipt of consultation to service initiation.

(d) Lack of referrals.

e. Risk management. The section chief will appoint an officer to serve as the section risk manager. The section risk manager will be responsible for developing generic screens for monitoring the program, and coordinating RM activities with the MEDDAC or MEDCEN risk manager.

f. Infection control.

(1) Local MEDDAC or MEDCEN infection control SOPs provide the policy guidance for infection control.

(2) Each OT section will have an internal infection control policy delineated in written clinic SOPs approved by the MEDDAC or MEDCEN infection control committee.

(3) An appointed infection control officer will develop generic screens to monitor the internal infection control program. This officer is also responsible for reviewing and updating section SOPs to assure compliance with the broader MEDDAC or MEDCEN infection control SOPs.

E–3. PT procedures

a. Section QA coordinator. The chief of the PT section or appointed section QAC will monitor the PT QA activities. Duties include at least—

(1) Maintaining liaison with the MTF QA committee.

(2) Developing monitors and generic screens.

(3) Analyzing and distributing QA data within the PT section as appropriate.

(4) Preparing PT QA reports.

(5) Evaluating the section QA program on an ongoing basis.

(6) Conducting RM per paragraph 3–5 and infection control in accordance with policy as stated in AR 40–5.

b. Model QAP. (See the Physical Therapy Quality Assurance Handbook.) This program must include the following:

(1) *Function.* The broad aspect of care that describes a process by which physical therapy services are delivered. All functions encompass the scope of physical therapy practice.

(2) *Indicators.* Specific components of care used to evaluate services rendered (yardstick of care).

(3) *Monitors.* Methods by which criteria are measured and indicators are assessed (a trend locator).

(4) *Criteria.* Measurable standards to evaluate the indicators (inches on the yardstick).

(5) *Data sources.* Bodies of information that are critically reviewed against criteria.

(6) *Problems.* Problems found must be followed up by an indication of corrective action.

c. Credentials review and privileging process.

(1) Credentials review includes validation of graduation from an accredited PT school, current licensure, specialty training, and current competence.

(2) Physical therapists granted clinical privileges include at least those performing NMSEs, electroneuromyography, inhibitive casting, and early intervention in the care of infants at high risk of death or disability (neonatal intensive care).

(3) Any physical therapist with appropriate qualifications may be privileged by the MEDDAC or MEDCEN commander to perform other duties.

(4) After 1 July 1989, individuals not licensed or awaiting notification of licensure will have all medical record entries countersigned by a licensed therapist.

(5) DA Forms 5440–21–R and 5441–21–R will be completed for

each privileged physical therapist at least every 2 years (except ARNG and USAR). See also paragraph 4–8*a* and *e*.

E–4. Records

a. QA data trend analysis, identified problems and actions, evidence of resolution, and recommendations will be given to the MTF QA committee quarterly per table 2–1.

b. Within HSC, QA findings including actions taken will be forwarded annually to Commander, U.S. Army Health Services Command, ATTN: HSCL–S, Fort Sam Houston, TX 78234–6000.

c. The Seventh MEDCOM and 18th MEDCOM PT and OT Activities will forward their QA findings on an annual basis to the respective chief, HQDA (DASG–DB), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Glossary

Section I
Abbreviations

AA
Alcoholics Anonymous

AC
Active Component

ACLS
advanced cardiac life support

ADA
American Dental Association

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADSW
active duty for special work

ADT
active duty for training

AFIP
Armed Forces Institute of Pathology

AG
adjutant general

AGR
Active Guard Reserve

AMEDD
Army Medical Department

AOC
area of concentration (formerly SSI)

AQCESS
Automated Quality of Care Evaluation Support System

ARCOM
Army Reserve Command

ARNG
Army National Guard

ARPERCEN
Army Reserve Personnel Center

ASD(HA)
Assistant Secretary of Defense (Health Affairs)

AT
annual training

ATLS
advanced trauma life support

BCLS
basic cardiac life support

CA
Cocaine Anonymous

CCC
community counseling center

CCU
coronary care unit

CDC
Centers for Disease Control

CE
continuing education

CEEP
Capital Expense Equipment Program

CJA
claims judge advocate

CONUS
continental United States

CPO
civilian personnel office

CRAE
conclusions; recommendations; action; evaluation (format)

DA
Department of the Army

DC
Dental Corps

DCCS
deputy commander for clinical services

DEA
Drug Enforcement Agency

DENTAC
dental activity

DHS
director of health services

DMIS
Defense Medical Information System

D.O.
Doctor of Osteopathy

DOD
Department of Defense

DRG
diagnosis-related group

DTF
dental treatment facility

ECFMG
Educational Commission for Foreign Medical Graduates

ECG
electrocardiogram

EMS
emergency medical services

ER
emergency room

FLEX
Federation Licensing Examination

FN
file number

FOIA
Freedom of Information Act

FORSCOM
Forces Command

FPM
Federal Personnel Manual

GCMCA
general courts-martial convening authority

GD
graduate dietitian

GHPE
Graduate Health Professions Education

HCP
health care provider

Hdbk
handbook

HQ
headquarters

HQDA
Headquarters, Department of the Army

HREC
health record

HSC
U.S. Army Health Services Command

ICU
intensive care unit

IDA
initial denial authority

IDT
inactive duty training

IMA
individual mobilization augmentee

IRR
Individual Ready Reserve

ITR
inpatient treatment record

JCAHO
Joint Commission on Accreditation of Healthcare Organizations (formerly JCAH)

MACOM
major Army command

MC
Medical Corps

M.D.
Doctor of Medicine (medical doctor)

MEB
medical evaluation board

MEDCASE
medical care support equipment

MEDCEN
medical center

MEDCOM
medical command

MEDDAC
Medical Department activity (Army)

MFR
memorandum for record

MPRJ
Military Personnel Records Jacket

MRI
magnetic resonance imaging

MTF
medical treatment facility

NA
Narcotics Anonymous

NCD
nutrition care division or directorate

NCLEX
National Council for Licensure Examinations

NCOIC
noncommissioned officer in charge

NMSE
neuromusculoskeletal evaluation

NPRC
National Personnel Records Center

OB/GYN
obstetrics and gynecology

OER
Officer Evaluation Report

OJT
on-the-job training

OPM
Office of Personnel Management

OSHA
Occupational Safety and Health Administration

OT
occupational therapy

OTJAG
Office of The Judge Advocate General

OTR
outpatient treatment record

PAD
patient administration division

PAF
provider activity file

PBAC
program budget advisory committee

PCE
potential compensable event

PCF
practitioner credentials file

PCS
permanent change of station

PT
physical therapy

QA
quality assurance

QAC
quality assurance coordinator

QAP
Quality Assurance Program

RC
Reserve Component

RM
risk management

RTF
residential treatment facility

SI
skill identifier (formerly ASI)

SOP
standing operating procedure

SSN
social security number

TAB
therapeutics agents board

TCF
training credentials file

TDY
temporary duty

TOE
table(s) of organization and equipment

TPU
troop program unit

TSG
The Surgeon General

UCMJ
Uniform Code of Military Justice

USAR
U.S. Army Reserve

USARCS
U.S. Army Claims Service

Section II
Terms

Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)
The Army's official program for prevention, identification, treatment, and management of personnel with alcohol-and-drug problems.

Alcohol abuse
The non-dependent use of alcohol to an extent that it has an adverse effect on the user's health or behavior, family, community, or DOD.

Alcohol dependence or alcoholism
Psychological and/or physiological reliance on alcohol as defined by the current Diagnostic and Statistical Manual III.

Appropriate
The determination that the service being provided is suited for the condition that is present; suitable for a particular person, condition, occasion, and/or place.

Appropriateness
The extent to which a particular procedure, treatment, test, or service is effective, is clearly indicated, is not excessive, is adequate in quantity, and is provided in inpatient, outpatient, home, or other settings best suited to the patient's need.

Appropriateness criteria
Criteria which represent the clinical circumstances that support a decision to perform a diagnostic, therapeutic, or surgical procedure.

Clinical competence
Personal and technical skills that lead to effective intervention in illness or injury.

Clinical consultant
The medical officer, who has an interest in and knowledge of alcohol and other drug abuse, appointed by the MTF commander to provide consultation and medical support to the CCC.

Community counseling center
The local installation element of the ADAPCP that provides outpatient counseling, education, and command consultation and liaison.

Complication
Any event, whether iatrogenic or spontaneous, either of omission or commission, that represents a significant deviation from the expected process or outcome of a particular medical or dental treatment.

Continuing education
Formal post-degree or post-certificate training exclusive of educational programs in specialty areas; courses of study that refresh; update and enhance knowledge, skills, and experience of professional personnel.

Continuity of care
The process for providing the ongoing appropriate level of care as the patient moves through the health care continuum.

Credentials
The documents which constitute evidence of training, licensure, experience, and expertise of a practitioner.

Drug abuse
The use or possession of illegal drugs or the nonmedical use of prescription or over-the-counter drugs.

Drug dependence
Psychological and/or physiological reliance on a psychoactive drug as defined by the current Diagnostic and Statistical Manual III.

Effectiveness
The degree to which action(s) achieve the intended health or dental result under normal or usual circumstances.

Efficiency
Optimal allocation of goods or services. In health or dental care, it is maximizing the units of effective care delivered for a given unit of resources used.

Evaluation
Analysis of collected, compiled, and organized data pertaining to important aspects of care. Data are compared with predetermined, clinically valid criteria; variations from criteria are judged to be justified or unjustified; and problems or opportunities to improve care are identified.

Focused review
Review that concentrates on a perceived problem area that may be a specific diagnosis, procedure, practitioner(s), patient(s), or other limited scope topic; done in place of a more comprehensive review or as a preliminary to it.

Health care personnel
Personnel involved in the delivery of health care.

Health care provider
Providers of direct patient care services.

Impaired health care provider
An HCP whose clinical practice, or supervision thereof, is adversely affected (or has the potential of being adversely affected) by alcohol or drug abuse or dependence, or by medical or psychiatric problems.

Important aspects of care
Clinical activities that involve a high volume of patients, that entail a high degree of risk for patients, or that tend to produce problems for patients. Such activities are deemed important for the purpose of monitoring and evaluation.

Incident (adverse event)
Any unintended or unexpected negative result that arises during patient care.

Indicator
A defined, measurable dimension (variable) of the quality or appropriateness of an important aspect of care. Indicators specify the patient care activities, events, occurrences, or outcomes that are to be monitored and evaluated in order to determine whether those aspects of patient care conform to current acceptable standards of practice.

License
A grant of permission by an official agency of a State, the District of Columbia, or a Commonwealth, territory, or possession of the United States to provide health care independently in a specified discipline in that jurisdiction. It includes, in the case of such care furnished in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide health care independently in a specified discipline.

Malpractice
A dereliction of professional duty or failure of professional skill or learning that results in death, injury, loss, or damage to the patient.

Monitoring
The systematic and ongoing collection, compilation, and organization of data pertaining to indicators for the quality and appropriateness of important aspects of care in order that problems or opportunities to improve care can be identified.

National Practitioner Data Bank
The organization developed according to provisions of Public Law 99–660 (The Health Care Quality Improvement Act of 1986).

Nursing plan of care
Any written documentation of the nursing process as it applies to an individual patient.

Obligated status
Active duty service obligation(s) resulting from entry into the Army, participation in the various subsidized accession programs (for example, Health Professions Scholarship Program, Uniformed Services University of the Health Sciences, Reserve Officers' Training Corps), or from participation in inservice or service sponsored professional education programs that include an active duty obligation.

PAF criteria definitions
a. Number of patients "discharged" identifies the total number by patients discharged and transferred out of the attending practitioner (excluding administrative transfers when the patient was not admitted for treatment). This includes inpatient deaths, but excludes patients for whom only records responsibility is assumed.

b. Number of patient "deaths (failed criteria)" identifies deaths which may have been contributed to by practitioner failure, delay, or inappropriate diagnosis or treatment.

c. Number of patients with "normal tissue (failed criteria)" identifies surgical cases with normal tissue found unacceptable by surgical cases review function.

d. Number of medical record "deficiencies" is determined by the medical record review function. (See para 4–12*a*(5)*(b).*)

e. Number of medical record "delinquencies" identifies documented instances of a practitioner's failure to complete records within prescribed time limits—in no instance longer than 30 days from patient discharge for total record completion.

f. Number of "transfusion variations" identifies instances of inappropriate blood use as determined by transfusion review or other QA review function.

g. Number of "drug use variations" identifies instances of inappropriate drug use as determined by pharmacy and therapeutic review function or other QA review.

h. Number of "validated complaints" identifies practitioner-directed patient complaints reviewed and found justified.

i. Number of "validated occurrences" identifies occurrences which have been attributed to a practitioner's act of commission or omission.

Patient care evaluation
A process, performed either concurrently or retrospectively, which assess in depth the quality and/or nature of the utilization of an aspect of health or dental care services. This often is accomplished by observation or medical record audit. Corrective action is taken where indicated and a subsequent analysis (followup) is made of the effect of the corrective action.

Peer
A person having similar training and experience within the same profession and to whom comparative reference is being made.

Peer review
An incident having the potential to lead to a claim against the government.

Potential compensable incident
An incident where a breach of the standard of care has occurred with resulting injury.

Practice or procedure variance
Any deviation from the accepted standards of care, practice or performance.

Practitioner
Military or civilian HCPs given privileges (privileged) to diagnose, initiate, alter, or terminate health care treatment regimens. This

definition includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, and physician assistants. When given individual clinical privileges, personnel from the following professionals may also be included: Physical therapists, occupational therapists, audiologists, clinical dietitions, clinical pharmacists, and speech pathologists.

Privileging
The processing through credentials committee channels of those individuals given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care.

Quality
The degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcome for a particular service, procedure, diagnosis, or clinical problem.

Quality assurance
A formally organized sequence of activities which combines assessment of the existing situations, judgments about necessary changes, development of plans to effect such changes, implementation of these plans, and reassessment to determine that the desired changes have taken place.

Residential treatment facility
The inpatient rehabilitation element of the ADAPCP which provides an intensive 6-week structured treatment program for eligible personnel in designated Army MTFs.

Standards
Professionally developed expressions of the range of acceptable variation in quality of care, generally with respect to specific services.

Standard of care
Identified levels of care that focus on the recipient of care and serve as clinical guidelines for the delivery of safe patient care and patient response to that care within a variety of clinical situations.

Standard of performance
Expected level of performance based on education, level of experience, and criteria of current position requirements.

Standard of practice
Identified levels of care that focus on health care personnel and serve as guidelines to assess their competence, experience, and education.

Supervision
The process of reviewing, observing, and accepting responsibility for assigned personnel. The following three levels of supervision are pertinent to clinical privileges:

a. Direct. The visual review of the provision of services to a patient(s) while those services are being provided during the major portion of the care. (The supervisor is actually there and sees what is going on.)

b. Indirect. May include a requirement that a physician or dentist is immediately available either by telephone or by actual presence. It may also include countersignature or authentication of medical record entries or reports or of orders prescribed by another, for example, residents.

c. Verbal. Involves the supervising officer in the decision-making process prior to implementing or changing a regimen of care.

Thresholds
Thresholds are preestablished levels or points which, when reached, will trigger intensive evaluation.

Utilization management
The planning, organization, directing, and controlling of medical or dental services in a cost-effective manner while maintaining acceptable standards.

Verified credentials
Documents for which confirmation of authenticity has been obtained from the primary source.

Section III
Special Abbreviations and Terms
There are no special terms.

RESERVED

INITIAL APPLICATION FOR CLINICAL PRIVILEGES

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10, USC, Section 1071.
Principal Purpose: To define the extent and limits of the practitioner's clinical privileges as a function of his or her training and experience.
Routine Uses: Determine and assess capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hospitals, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulating bodies.
Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*		2. SOCIAL SECURITY NO. *(SSN)*	3. GRADE
4. CORPS	5. DATE OF ASSIGNMENT *(Day, Mo., Yr.)*	6. ASSIGNMENT LOCATION	

SECTION B - PROFESSIONAL EDUCATION

7. NAME OF PROFESSIONAL SCHOOL	8. LOCATION	9. YRS. ATTENDED		10. TYPE DEGREE	11. DEGREE COMPLETED *(Day, Mo., Yr.)*
		FROM	TO		

SECTION C - POSTGRADUATE TRAINING

12. NAME OF HOSPITAL OR INSTITUTION	13. LOCATION	14. TYPE PROGRAM *(Residency, etc.)*	15. DURATION	16. DATE COMPLETED *(Day, Mo., Yr.)*

SECTION D - PREVIOUS HOSPITAL ASSIGNMENTS

17. NAME OF HOSPITAL	18. LOCATION	19. CLINICAL SERVICE/DEPT. ASSIGNED	20. INCLUSIVE DATES *(Day, Mo., Yr.)*	
			FROM	TO

SECTION E - CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

21. BOARD ELIGIBLE FROM *(Date)*	22a. BOARD EXAM TAKEN *(Date)*	22b. CHECK ☐ Total ☐ Partial	24. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*
23. BOARD CERTIFIED? *(If yes, give name of Board(s).* ☐ Yes ☐ No			

SECTION F - CREDENTIALS ACTION HISTORY *(If "Yes" to any of the following, give full details on a separte sheet.)*

	YES	NO		YES	NO
25. Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, or voluntarily surrendered?			28. Have your privileges at any institution ever been limited, restricted or revoked?		
26. Have you ever been refused membership in a hospital medical staff?			29. Has your narcotics registration ever been suspended or revoked?		
27. Has your request for any specific clinical privileges ever been denied or granted with stated limitations?			30. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?		

SECTION G - CLINICAL PRIVILEGES APPLIED FOR

31. LIST THE APPROPRIATE DA FORM 5440-R-SERIES AND ATTACH TO THIS FORM.

32a. DEA NO. *(If any)*	32b. DATE	33a. STATE LICENSURE*(If any)*	33b. DATE	33c. EXPIRATION DATE

The information contained herein is true to the best of my knowledge and belief.	34a. SIGNATURE OF APPLICANT	34b. DATE

35. Recommendations

a. PROVISIONAL STATUS	FROM	TO

b. CLINICAL PRIVILEGES

☐ Granted as Requested. ☐ Modified *(Specify in item 35c.)*

c. MODIFICATIONS

36. Reviewed By		d. CREDENTIALS COMMITTEE *(Signature)*	E. DATE
a. DEPARTMENT/SERVICE	b. DATE	**37. Approved By**	
c. SIGNATURE		a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE

38. Appointment Status

a. CLINICAL PRIVILEGES

☐ Granted as Requested. ☐ Modified *(Specify in item 38b.)*

b. MODIFICATIONS

39. Reviewed By		d. CREDENTIALS COMMITTEE *(Signature)*	e. DATE
a. DEPARTMENT/SERVICE	b. DATE	**40. Approved By**	
c. SIGNATURE		a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE

PERFORMANCE ASSESSMENT

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD COVERED	
FROM	TO

AREAS OF ASSESSMENT *(Check Appropriate Box. Qualifying statements may be made under "Comments" below.)*	UNSATIS-FACTORY	SATIS-FACTORY	GOOD	EXCEL-LENT
1. Basic clinical knowledge displayed.				
2. Clinical judgment.				
3. Clinical performance.				
a. Outpatient.				
b. Inpatient.				
c. Operating room.				
4. Communication skills.				
5. Rapport with patients.				
6. Relationship with colleagues.				
7. Cooperation with hospital/clinic personnel.				
8. Appearance.				
9. Emotional stability.				
10. Apparent physical health.				
11. Professional conduct.				
12. Ethical conduct.				
13. Leadership capability.				
14. Quality and timeliness of medical/dental record documentation.				
15. Participation/attendance at staff committee meetings and professional activities.				

16. COMMENTS *(Unsatisfactory areas should be addressed.)*

17a. NAME OF ASSESSED INDIVIDUAL	17b. GRADE	19. SPECIALTY/DUTY ASSIGNMENT
17c. TITLE		
18a. TYPED NAME OF SUPERVISOR	18b. GRADE	20. MEDICAL/DENTAL TREATMENT FACILITY *(Name and Address)*
18c. TITLE		
18d. SIGNATURE		

DELINEATION OF PRIVILEGES - ANESTHESIA

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges in anesthesiology will be based on education, clinical training, demonstrated skills, and capacity to manage procedurally-related complications.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Local infiltration anesthesia, topical application, and minor nerve blocks in ASA Risk Class 1 and 2 patients.				
Category II. Category I - Specific anesthesia procedures under specified conditions in ASA Risk Classes 1, 2, and 3.				
Category III.* Categories I and II and ASA Risk Classes 1, 2, 3, 4, 5. Individuals who by training and experience *(Diplomate of the American Board of Anesthesiology or possess training equivalent to that required by the American Board of Anesthesiology)* are competent in:				
a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures.				
b. The support of life functions under the stress of anesthetic and surgical manipulations.				
c. The clinical management of the patient unconscious from whatever cause.				
d. The management of problems in pain relief.				
e. The management of problems in cardiac and respiratory resuscitation.				
f. The application of specific methods of respiratory therapy.				
g. The clinical management of various fluid, electrolyte, and metabolic disturbances.				
TYPE PATIENT				
a. Adult				
b. Pediatric				
c. Newborn				
d. Obstetrical Only				
TYPE ANESTHESIA				
a. General				
b. Regional				
(1) Spinal				
(2) Epidural				
(3) Caudal/Pudendal				
(4) Nerve Block				
(5) Auxiliary Blocks				
(6) Intravenous *(Bier-Block)*				
SPECIAL PROCEDURES				
a. Arterial Pressure Lines				
b. Central Venous Pressure Line				
c. Swan-Ganz Catheter				
d. Arterial/Venous Puncture				
e. Hypothermia				
f. Other *(Specify)* →				
Classification of physical status and anesthetic risk devised by the American Society of Anesthesiologists:				

Class 1. Normal, healthy patient.
Class 2. Patient with mild systemic disease.
Class 3. Patient with severe systemic disease that limits activity but not incapacitating.
Class 4. Patient with an incapacitating disease that is a constant threat to life.
Class 5. Morbid patient who is not expected to survive for 24 hours, with or without the operation.

* Where Category III privileges are granted, they will be accompanied by specific limitations where indicated.

DELINEATION OF PRIVILEGES RECORD

For use of this form, see AR 40-68; the proponent agency is OTSG

1. PERIOD FROM TO

2. Check the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. OB/GYN Nurse Practitioners
	C. Family Practice		K. Psychiatry		S. Physician Assistants
	D. Internal Medicine & Subspecialty		L. Psychology		T. Emergency Medicine
	E. Neurology		M. Radiology/Nuclear Medicine		U. Other Specialty *(Specify)*
	F. Obstetrics & Gynecology		N. Surgery		
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC	B. STATUS ☐ (1) Temporary ☐ (2) Conditional ☐ (3) Courtesy ☐ (4) Consulting ☐ (5) Full *(Appointment Status)*	C. CLINICAL PRIVILEGES ☐ (1) Granted as Requested ☐ (2) Modified as Recommended ☐ (3) Other *(See Remarks)*

D. DEPT./SVC *(Specify)*	E. DATE	G. CREDENTIALS COMMITTEE	H. DATE
F. SIGNATURE		I. SIGNATURE	

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER	B. SIGNATURE	C. DATE

5. Remarks

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*	B. BOARD EXAMINATION TAKEN *(Date)* ☐ Total ☐ Partial	C. BOARD CERTIFIED ☐ No ☐ Yes *(Give Name of Board)*
D. RECERTIFICATION *(Board and Date)*	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*
G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*	J. NAME OF APPLICANT OR PRACTITIONER
I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*		K. SIGNATURE / L. DATE

DELINEATION OF PRIVILEGES - DENTISTRY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5504A-R Must be Completed and Attached to this Form)

CHECK ONE

☐ AC ☐ USAR ☐ ARNG

REQUESTED BY

DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Eligibility to perform dental procedures must be based on education, training, experience, and demonstrated current competency. Privileges beyond the capability or scope of the Dental Facility will not be granted. Dental privileges are divided into two categories.	APPROVED WITHOUT LIMITATION	QUALIFIED ASSISTANT REQUIRED	MAY ASSIST ONLY	NOT APPROVED
Category I. General Dentists *(63A)* to include GPR graduates. Practitioners who have successfully graduated from a dental school program accredited by the American Dental Association may be delineated privileges in general dentistry. Privileges are listed in the "Instructions for Delineation of Privileges - Dentistry, General Dentistry *(SSI 63A)*". This category includes DAC and Foreign National dentists hired under appropriate regulations.				
Category II. Specialists Performs Category I procedures. Practitioners are board certified, board eligible, or have completed residency in the specialty. Practitioners who treat oral disease or problems requiring skills usually acquired during dental residency in any specialty.				
SPECIAL PROCEDURES ***(Check specialty area requested. Privileges are listed in the Instructions for Delineation of Privileges - Dentistry)***				
a. General Dentistry *(63B)*				
b. Periodontics *(63D)*				
c. Endodontics *(63E)*				
d. Prosthodontics *(63F)*				
e. Dental Public Health *(63H)*				
f. Pediatric Dentistry *(63K)*				
g. Orthodontics *(63M)*				
h. Oral Surgery *(63N)*				
i. Oral Pathology *(63P)*				
OTHER PRIVILEGES ***(Specify)***				
EXCEPTIONS ***(Recommended by Service/Clinic Chief)***				

DELINEATION OF PRIVILEGES - FAMILY PRACTICE

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

Assignment of clinical privileges will be based on education, clinical training, and demonstrated competence.

Family Practice practitioners will demonstrate skills in interviewing, examination, assessment, and management of patients with general medical, obstetrical, surgical, and psychiatric health problems. Full privileges include admission privileges to all services to include the intensive care areas of the hospital *(MICU/CCU/SICU)*. Seriously ill patients will be managed in consultation with or direct referral to specialty physicians.

Family Practice clinical privileges are divided into four major categories. The category or privilege requested should be specified.

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Emergency Care Uncomplicated illnesses or problems which have low risk to the patient such as routine prenatal health care, incision and evacuation of thrombosed hemorrhoids, and acute and chronic outpatient care in clinics and emergency services. Residency training is not required but reasonable experience in the care of patients with these problems or in the performance of these procedures is required.				
PROCEDURES/SKILLS ***(Check Desired Privilege(s))***				
a. Proctosigmoidoscopy				
b. ECG Performance and Initial Interpretations				
c. Basic Radio Interpretations *(Skull, spine, CXR, abdomen, IVP, and extremity)*				
d. Insertion/Removal of IUD				
e. Regional Anesthesia				
f. Splinting/Casting/Immobilizing of Simple Fractures				
ADDITIONAL PRIVILEGES ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				
Category II. Category I Major illnesses, injuries, conditions or procedures which do not have significant risk to life such as in the provision of care for uncomplicated psychiatric, orthopedic, medical, pediatric, or obstetrical patients. Requires at least significant graduate Family Practice training or considerable documented experience in the care of these conditions, or performance of these procedures.				
a. Lumbar Puncture *(Adult and Child)*				
b. Infant/Newborn Resuscitation				
c. Vaginal Delivery *(Uncomplicated)*				
d. Endometrial Biopsy				
ADDITIONAL PRIVILEGES ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category III. Categories I and II Major illnesses, injuries, conditions, or procedures which may carry some substantial threat to life such as heat stroke, pre-eclampsia, vertebral fractures, initial management of multiple trauma victims, myocardial infarctions, burns, and behavioral modification counseling. Requires Family Practice residency completion and/or board certification.				
PROCEDURES/SKILLS ***(Check desired privilege(s))***				
a. Joint Aspiration/Injection				
b. Diagnostic Thoracentesis With or Without Biopsy				
c. Abdominal Pericentesis				
d. Bone Marrow Aspiration and Biopsy				
e. Low Forceps Delivery				
f. Vacuum Extraction				
g. Obstetrical Anesthesia				
h. Culdocentesis				
i. Dilation & Curettage				
j. First Assist at Major Surgical Procedures				
k. Flexible Sigmoidoscopy				
l. Reduction of Simple Fractures of Extremities				
j. Vasectomy				
ADDITIONAL PRIVILEGES ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				
Category IV. Categories I, II, and III Unusually complex or critical patient care problems or procedures with serious threat to life such as complicated myocardial infarctions, c-sections, and prolonged assisted pulmonary ventilation. Requires extensive experience beyond board certification. Consultation or supervision by a subspecialty trained physician is mandatory.				
a. Swan-Ganz Catherization				
b. Management of Severe Pre-eclampsia				
c.				
d.				
e.				
f.				
ADDITIONAL PRIVILEGES ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				

DELINEATION OF PRIVILEGES - INTERNAL MEDICINE AND SUBSPECIALTY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

Privileges in the Department of Medicine are granted for both clinical areas and specific procedures. All practitioners requesting privileges in the Department of Medicine will use this form regardless of specialty.

Four categories *(levels)* of clinical privileges may be granted for each clinical area listed below. The category of privilege requested, if any, in each area should be specified.

Category I. Emergency Care.

Uncomplicated illnesses or problems which have low risk to the patient.

Non-specialists with little or no residency training but with reasonable experience in the care of these conditions.

Category II. Category I.

Major illnesses, injuries, conditions or procedures, but with no significant risk to life.

Significant graduate training in the specialty related to the conditions, or considerable experience in the care of the conditions.

Category III. Categories I and II.

Major illnesses, conditions, or procedures which carry substantial threat to life.

Board certification* or other extensive training and experience in the care of these conditions. *Completion of three-year residency training may be accepted in lieu of board certification for a period ***not to exceed five years*** following completion of training for accessions/appointments after 1982.

Category IV. Categories I, II, and III.

Unusually complex or critical diagnoses or treatment with serious threat to life.

Extensive relevant subspecialty training or experience beyond board certification.

NOTE: If a practitioner is not granted privileges in Category III or IV, consultation with a physician in one of these categories is mandatory for a patient with a medical condition that increases surgical or anesthetic risk, when a surgical procedure is contemplated.

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, training, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
CLINICAL AREAS. ***(Write I, II, III, or IV to Indicate the Category or Privileges in Each Area That You Are Requesting Privileges.)***				
a. Allergy-Immunology				
b. Cardiology				
c. Dermatology				
d. Endocrine and metabolic diseases				
e. Gastroenterology				
f. Hematology				
g. Infectious disease				
h. Internal medicine				
i. Nephrology				
j. Pulmonary disease				
k. Rheumatology				
l. Oncology				
SPECIAL PROCEDURES ***(Check the Procedures for Which Privileges are Requested and Attach a Statement Indicating Your Qualifications to Perform Each of Them.)***				
Special Studies, Invasive				
a. Arterial puncture and cannulation				
b. Angiography, cerebral				
c. Arteriography				
d. Arthrocentesis				
e. Bronchial brushing				
f. Bronchial lavage				
g. Bronchograms				
h. Bone marrow aspiration				
i. Cardiac Catherization				
j. Cardiac pacemaker *(Transvenous)*				

PRIVILEGES. (* Privileges will be granted only for the type endoscopic procedure for which competency has been verified (formal training/demonstrated competency.)	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Special Studies, Invasive *(Continued)*				
k. Cholangiography, percutaneous				
l. Cisternal Tap				
m. Hemodialysis				
n. Hemofiltration				
o. Lymphangiography				
p. Myelography				
q. Paracentesis, abdominal				
r. Pericardiocentesis				
s. Peritoneal dialysis				
t. Phlebography				
u. Plasmaphoresis				
v. Pneumoencephalography				
w. Spinal tap				
x. Subclavian puncture				
y. Swan-Ganz catherization				
z. Thoracentesis				
Other *(Specify)*				
Biopsy and Excision. Needle Biopsy of:				
a. Bone Marrow				
b. Kidney				
c. Liver				
d. Lung				
e. Thyroid				
f. Pericardial biopsy *(Closed)*				
g. Peritoneal biopsy *(Closed)*				
h. Pleural biopsy *(Closed)*				
i. Skin biopsy				
j. Small intestinal biopsy with Crosby capsule & Shiner tube				
Other *(Specify)*				
*** Endoscopy** — **With Biopsy**				
a. Bronchoscopy				
b. Colonoscopy				
c. Duodenoscopy				
d. Esophagoscopy				
e. Mediastinoscopy				
f. Peritoneoscopy				
g. Sigmoidoscopy				
Other *(Specify)*				

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Special Studies, Non-Invasive and Other Procedures	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
a. Echocardiography				
b. ECG interpretation				
c. Electroconvulsant therapy				
d. EEG interpretation				
e. Electromyography				
f. Endotracheal intubation				
g. Other intubation *(Specify)*				
h. Esophageal dilatation				
i. Hypnosis				
j. Peripheral vascular studies *(Non-Invasive)*				
k. Phonocardiography				
l. Pulmonary function interpretation				
m. Radioactive isotopes, diagnostic				
n. Radioactive isotopes, therapeutic				
o. Vectorcardiography interpretation				
p. Respirator management				
q. * Diagnostic/Therapeutic radiology *(Specify)*				
Other *(Specify)*				
EXCEPTIONS TO DIAGNOSIS, TREATMENT OR PROCEDURES ***(As Recommended by Department Chief)***				

* Requires special qualifications of training and experience in equipment use and in the interpretation of results.

DELINEATION OF PRIVILEGES - NEUROLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, clinical training, & demonstrated competence. Neurology clinical privileges are divided into four major categories. The category of privilege requested should be specified.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Emergency Care Uncomplicated illnesses or problems which have low risk to the patient such as recurrent headache or uncomplicated epilepsy or with no available treatment such as completed ischemic stroke, progressive dementia in the elderly, and cerebral palsy. Internists, pediatricians, family practitioners, and psychiatrists where neurology training has been included in their residency experience.				
EXCEPTIONS *(Recommended by Department Chief)*				
Category II. Category I Major illnesses, injuries, conditions or procedures with little immediate risk to life, in child or adult such as multiple sclerosis, Parkinson's disease, and transient ischemic attacks. Management of crippling or life threatening disorder where category III and IV supervisor is available. Performance of EMG, EEG, evoked potentials and similar tests for which the applicant has had specific training. One year of general postgraduate education and two years of specialty training in adult or child neurology.				
EXCEPTIONS *(Recommended by Department Chief)*				
Category III. Categories I and II Management of all conditions affecting the nervous system in adults except for those patients requiring neurosurgical intervention. Management of common non-life threatening conditions in children. Completion of neurology training in adult neurology.				
EXCEPTIONS *(Recommended by Department Chief)*				
Category IV. Categories I, II, and III Management of all neurologic conditions affecting children except those children requiring neurological intervention (child neurology). Diagnosis and management of refractory seizure disorders, unusual neuromuscular disorders or other problems reflecting additional subspecialty skills. Individual patients display complexity exceeding those of Category III. Require post residency fellowships or child neurology residency/fellowship.				
SPECIAL PROCEDURES. *(Check the Procedures for Which Privileges are Requested)*				
a. Lumbar Puncture				
b. Cisternal Tap				
c. Subdural Tap *(Infants)*				
d. Electroencephalogram *(EEG)*				
e. Brain Stem Auditory Evoked Response				
f. Visual Evoked Response				
g. Somatosensory Evoked Response				
h. Electromyogram *(EMG)*				
i. Myelogram				
Other *(Specify)*				
EXCEPTIONS *(Recommended by Department Chief)*				

DELINEATION OF PRIVILEGES - OBSTETRICS AND GYNECOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5504A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Obstetric-gynecologic clinical privileges are divided into four categories *(levels)*. These categories are based on classification developed by the American College of Obstetricians and Gynecologists and published in **Standards for Obstetric-Gynecologic Services**, Sixth Edition. Check category and procedures requested.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Emergency Care. Diagnosis and therapy with minimal threat to life. Physician has minimal formal training in the discipline, but has training and experience in the care of specific conditions.				
a. Normal Antepartum and Postpartum Care				
b. Normal Labor and Delivery				
c. Maternal-Fetal Monitoring				
d. Episiotomy and Repair of Second Degree Laceration				
e. Local Infiltration Anesthesia				
f. Pudendal Block Anesthesia				
g. Use of Oxytocic Drugs After Completion of Third Stage				
h. Sigmoidoscopy				
Category II. Category I Major diagnosis and therapy but with no significant threat to life. Physician has the training specified below, and experience in the care of specific conditions.				
MONTHS TRAINING IN OBSTETRIC PROGRAM / MONTHS TRAINING IN GYNECOLOGIC PROGRAM				
a. Cervical Dilation and Curettage *(Including Vacuum)*				
b. Biopsy of Cervix, Endometrium, or Vulva				
c. Abdominal Salpingo-oopherectomy, Ovarian Cystectomy				
d. Abdominal Tubal Interruption				
e. Incidental Appendectomy				
f. Amniocentesis				
g. Repair of Third and Fourth Degree Lacerations				
h. Drainage/Marsupialization of Bartholin Cyst				
i. Fetal Scalp Sampling				
j. Neonatal Resuscitation				
k. Neonatal Resuscitation				
l. Elective Low Forceps				
m. Manual Removal of Placenta and Postpartum Uterine Exploration				
n. Circumcision of Newborn				
Category III. Categories I and II Major diagnosis and therapy with possible threat to life. Physician has completed residency training in the specialty or has extensive training or experience in the care of specific conditions.				
a. Hysterosalpingography				
b. Hysteroscopy				
c. Laparoscopy, Diagnostic and Operative				
d. Ureteroscopy and Cystoscopy				
e. Supraclavicular or Other Superficial Node Biopsy				
f. Abdominal Hysterectomy				

REQUESTED BY		DATE			
	PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
		APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
	g. Partial Omentectomy				
	h. Myomectomy and Uterine Plastic Procedures				
	i. Urethrovesical Suspension				
	j. Repair of Cystocele and Rectocele				
	k. Repair of Injury to Bladder				
	l. Vaginal Hysterectomy				
	m. Vaginal Tubal Interruption				
	n. Cervical Conization				
	o. Cervical Cerclage				
	p. All Vaginal Deliveries				
	q. All Caeserean Deliveries				
	r. Intrauterine Radioactive Source Applications				
	s. Venous Catheter Insertion				
	t. Paracervical Anesthesia				
	u. Tubal Reconstructive Procedures Not Using Microsurgery				
	Category IV. Categories I, II, and III Unusually complex or critical diagnosis and therapy with possible serious threat to life. Physician has formal training in specific diagnosis or therapy. This training may have been within residency.				
	a. Extirpative and Reconstructive Gynecologic Surgery, Including Radical Hysterectomy, Vulvectomy, Lymph-adenectomy, and Exenteration				
	b. Surgical Repair of Injury to Bowel, Ureter, and Pelvic Vessels				
	c. Bowel Resection and Bypass				
	d. Bowel-Urinary Conduits				
	e. Tubal Reconstructive Procedures Using Microsurgery				
	f. Urodynamic Examination				
	g. Colposcopy				
	h. Obstetric Ultrasound Imaging				
	i. Intra-amniotic Operative Procedures				
	j. Surgical Application of Lasers				
	k. Placement of Intra-arterial Catheter				
	l. Regional Anesthesia				
	CATEGORY I, II, III, IV *(Identify Category)*				
	EXCEPTIONS *(Specify)*				
	ADDITIONAL PRIVILEGES *(Specify)*				

DELINEATION OF PRIVILEGES - OPTOMETRY SERVICE

For use of this form, see AR 40-68; the proponent agency is OTSG

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REQUESTED BY

DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges in optometry will be based on education, clinical training, experience, and demonstrated competence. The category of privilege requested should be specified.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
Category I. Privileges in this category are for uncomplicated illnesses, injuries, or routine procedures which may require diagnostic drugs. When doubt exists as to the diagnosis or in cases in which improvement is not soon apparent, consultation will be sought. Privileges may be granted to those optometrists who have satisfactorily completed formal Optometry training but have not been licensed to practice Optometry *(requires direct supervision until licensed).* **Examples:** Administration of commonly used vision/eye tests with guidance in interpretation of test results and in selection of more specialized diagnostic measures. Assignment of patients whose vision/eye disorders are not severe.					
Category II. Privileges include Category I, plus practitioners may evaluate, diagnose and treat difficult and complex vision//eye disorders. May act as consultants but are expected to request consultation when: (1) The diagnosis and/or management remains in doubt over an unduly long period of time; (2) Unexpected complications arise which are outside this level of competence; (3) specialized treatment measures are contemplated with which they are not familiar. The use of selected therapeutic drugs and the writing of prescriptions for selected medications may be granted when recommended by the Therapeutic Agents Board, the credentials committee, and the physician charged with direction of the clinical activities concerned, and approved by the Commander. Privileges may be granted to those those in optometrists who have satisfactorily completed formal Optometry training or have satisfied the Credentials Committee with their training, experience and competence. **Examples:** Diagnostic Drugs; Ocular Pathology; Therapeutic Drugs; Surveillance; Occupational Vision; Ocular Injury					
Category III Privileges include those in Categories I and II to the extent that qualification criteria are met, plus those associated with illnesses or problems requiring an unusual degree of expertise and competence. Practitioners with these privileges have the highest level of competence within a given field and are qualified to act as consultant but will request consultation when needed. Practitioners with these privileges are expected to have training and experience considered appropriate for a subspecialty. Examples: Visual Evoked Response. Research Protocol Administration on Use of Selected Therapeutic Drugs. Evaluate, coordinate with Opthalmology and co-manage acute ocular conditions requiring therapeutic treatment and close monitoriing through duration of symptoms. Co-manage complex or critical illnesses, injuries or conditions which carry a serious threat to vision when no trained eye physician is available.					
ADDITIONS *(Specify)*					
EXCEPTIONS *(Recommended by Department Chief)*					

DELINEATION OF PRIVILEGES - PATHOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Delineation of privileges must be based on an individual's education, training, experience, and demonstrated current competency.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUALIFIED SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Board certified or Board eligible in clinical and/or anatomic pathology but requires immediate supervision. **Category II.** Board certified in clinical and/or anatomic pathology and requires no supervision. **Category III.** Board certified with additional certified competence in subspecialized area or with appropriately documented training and experience beyond board certification.				
AREAS OF ANATOMIC AND CLINICAL PATHOLOGY ***(Write Category I, II, or III to Indicate Level of Privileges Requested.)***				
Anatomic Pathology				
a. Surgical Pathology				
b. Autopsy Pathology				
c. Cytopathology				
d. Neuropathology				
e. Dermatopathology				
f. Electron Microscopy				
g. Immunohistology				
h. Forensic Pathology				
ADDITIONS ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				
Clinical Pathology				
a. Clinical Chemistry				
b. Hematopathology				
c. Immunohistology				
d. Blood Banking				
e. Clinical Microscopy				
f. Microbiology				
g. Radioisotopic Pathology				
h. Serology				
ADDITIONS ***(Specify)***				
EXCEPTIONS ***(Recommended by Department Chief)***				

DELINEATION OF PRIVILEGES - PEDIATRICS

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5504A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, training, and demonstrated competence. Pediatric clinical privileges are divided into four major categories. The category of privilege requested should be specified.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Emergency Care. Supervision and care of routine term newborns and uncomplicated pediatric patients; i.e., illnesses, injuries, conditions or procedures which have low risk to the patient. Non-specialists with little or no pediatrics residency training, but with reasonable experience in care of these conditions.				
PROCEDURES/SKILLS *(Check Desired Privilege(s))*				
a. Venipuncture				
b. Lumbar puncture				
c. Urethral catheterization				
d. Incision and drainage of abscess				
e. Other *(Specify)*				
EXCEPTIONS *(Recommended by Department Chief)*				
Category II. Category I Major illnesses, injuries, conditions or procedures but with no significant risk to life. Significant training or experience in pediatrics, not necessarily board certified *(e.g., undiagnosed anemia; status asthmaticus; routine pre-op/post-op care of pediatric patients; lumbar puncture and arterial blood gasses, except newborns).*				
PROCEDURES/SKILLS *(Check Desired Privilege(s))*				
a. Subdural taps on infants with open fontanelle				
b. Pleuracentesis				
c. Peritoneal tap				
d. Saphenous or antecubital vein cutdowns				
e. Arterial puncture				
f. Intubations				
(1) Oro-trachael				
(2) Naso-tracheal intubation				
(3) Suprapubic puncture				
(4) Insertion of chest tube				
g. Exchange transfusion				
h. Sigmoidoscopy				
i. Proctoscopy				
j. Pre-oral biopsy				
k. Skin biopsy				
l. Other *(Specify)*				
EXCEPTIONS *(Recommended by Department Chief)*				

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category III. Categories I and II Major illnesses, injuries, conditions, or procedures which carry substantial threat to life. Board certification in pediatrics* or other extensive training and experience in the care of these conditions *(e.g., meningitis, drug overdose, erythroblastosis fetalis; neonatal resuscitation).* * Completion of three-year residency training in pediatrics may be accepted in lieu of board certification for a period ***not to exceed five years*** following completion of training for accessions/appointments after 1982.				
PROCEDURES/SKILLS ***(Check desired privilege(s))***				
a. Lung puncture				
b. Cardioversion				
c. Pericardiocentesis				
d. Bone marrow aspiration				
e. Bone marrow biopsy				
f. Administration of chemotherapy				
(1) Systematic chemotherapy				
(2) Intrathecal chemotherapy				
g. Endoscopy				
k. Intestinal biopsy				
l. Other *(Specify)*				
EXCEPTIONS ***(Recommended by Department Chief)***				
Category IV. Categories I, II, and III Unusually complex or critical illnesses, injuries, conditions or procedures which carry a serious threat to life. Extensive relevant subspecialty training or experience beyond board certification in pediatrics *(e.g., leukemia; respiratory failure; neonatal intensive care; renal dialysis).*				
PROCEDURES/SKILLS ***(Check desired privilege(s))***				
a. Bronchoscopy				
b. Pleural biopsy				
c. Lung biopsy, closed				
d. Cardiac catheterization				
e. Angiography				
f. Lymphangiography				
g. Kidney biopsy				
k. Bone marrow transplantation				
l. Other *(Specify)*				
EXCEPTIONS ***(Recommended by Department Chief)***				

DELINEATION OF PRIVILEGES - PODIATRY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, training, and demonstrated competence. Check category of privilege requested.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Treat routine conditions of the foot and works under the supervision of a privileged podiatrist who assumes full responsibility of the provider's acts.				
Category II. Category I - Examine, diagnose, and treat conditions of the feet requiring skills acquired during post-residency specialty training. Consultations should be used when there is doubt concerning the diagnosis or when there is evidence of systemic disease, as first manifested by pedal symptoms.				
Category III. Categories I and II. Board certified or eligible. Prevention, diagnosis and treatment of complications involving the foot, arising from various systemic diseases, as well as the palliative and corrective treatment of local foot pathology.				
AREAS OF FOOT PATHOLOGY ***(Check Category I, II, or III for Privileges Performed.)***				
a. General Practice				
b. Foot Surgery				
(1) Common Surgical Procedures on Forefoot				
(2) * Complex Reconstructive Surgery				
c. Podiatric Dermatology				
d. Foot Orthopedics				
e. Podopediatrics				
f. Podogeriatrics				
g. X-Ray Services *(Interpretation)*				
h. Other *(Specify)*				
EXCEPTIONS ***(Recommended by Department Chief)***				

* Requires supervision by a qualified orthopedic surgeon.

DELINEATION OF PRIVILEGES - PSYCHIATRY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Delineation of privileges must be based on an individual's education, training, experience, and demonstrated current competency. Check the appropriate category.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Category I. Physicians not board eligible in psychiatry with little or no residency training, but with considerable experience in the care of mental disorders and qualified for the general practice of medicine.				
Category II. A psychiatrist who is board eligible in Psychiatry.				
Category III. Psychiatrists who are board certified by the American Board of Psychiatry and Neurology or its equivalent.				
Category IV. Specialized fellowship training beyond board eligibility or board certification in General Psychiatry. Requires extensive subspecialty fellowship training or experience in the areas noted below.				
Subspecialties (*Check*)				
a. Child Psychiatry				
b. Psychoanalysis				
c. Child Psychoanalysis				
d. Forensic Psychiatry				
e. Administrative Psychiatry				
f. Geriatric Psychiatry				
g. Consultant-Liaison Psychiatry				
h. Psychosomatic Medicine				
Other *(Specify)*				
Privileges Requested (*Check*)				
a. Assessment and Diagnosis of Mental Disorders				
b. Inpatient Psychiatric Treatment				
c. Alcohol/Drug Residential Treatment				
d. Adult Psychotherapy				
(1) Individual				
(2) Marital				
(3) Family				
(4) Group				
e. Child and Adolescent Psychiatry				
(1) Assessment and Diagnosis				
(2) Psychotherapy				
(a) Family				
(b) Group				
(3) Psychopharmacotherapy				
f. Somatic Therapy				
(1) Psychopharmacotherapy				
(2) Biofeedback Therapy				
(3) Electro-Convulsive Therapy				
(4) Amytal Interview				

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED
Privileges Requested *(Continued)* (Check)				
g. Consultation				
(1) Command				
(2) Medical/Surgical Activities				
(3) Community Organizations				
(4) School				
h. Specialized Skills				
(1) Forensic Psychiatry				
(2) Psychoanalysis				
(3) Child Psychoanalysis				
(4) Geriatric Psychiatry				
(5) Behavior Therapy				
(6) Gestalt Therapy				
(7) Hypnotherapy				
Other *(Specify)*				
i. Research				
j. Other *(Specify)*				

DELINEATION OF PRIVILEGES - PSYCHOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Delineation of privileges must be based on an individual's education, training, experience, and demonstrated current competency. Check the appropriate category.	APPRD. WITHOUT LIMITATION	APPRD REQUIRES QUAL. SUPRV.	APPRD. WITH MODIFICATIONS	NOT APPRD.
Category I. Assists in performance of psychological and other services and works under the supervision of a privileged clinical psychologist who assumes full responsibility for the provider's acts.				
Category II. Practitioner has PH.D. or PsyD in clinical psychology but is not yet licensed. Provides full range of psychological services as qualified to deliver by virtue of training. Participates in team delivery of services, research and teaching. Receives licensure qualifying supervision from regional psychologist or supervising psychologist designated by regional psychologist. May be appointed as supervising psychologist for Category I.				
Category III. Practitioner has PH.D. or PsyD in clinical psychology and is licensed. Skilled in the areas of psychological assessment, intervention, and administration of services. Delivers psychological services to individuals and treatment teams. May be appointed as supervising psychologist for Category I or II.				
Category IV. Practitioner has PH.D. or PsyD in clinical psychology and is licensed and board certified. Recognized as possessing high level of skill in areas of assessment, intervention, and administration. May be appointed as supervising psychologist for Category I or II.				
Privileges Requested *(Check)*				
a. Assessment in psychological diagnosis				
b. Assists in inpatient management of mental disorders				
c. Psychological assistance in alcohol/drug residential treatment				
d. Outpatient psychological treatment				
e. Psychotherapy				
(1) Psychoanalytical oriented psychotherapy *(Individual)*				
(2) Behavior therapy				
(3) Gestalt therapy				
(4) Hypnotherapy				
(5) Transactional analysis				
(6) Group therapy				
(7) Marital therapy				
(8) Family therapy				
(9) Sexual dysfunction therapy				
(10) Psychosomatic therapy				
(11) Brief therapy				
f. Child psychotherapy				
g. Adolescent psychotherapy				
h. Somatic psychotherapy				
(1) Biofeedback therapy				
(2) Hypnotherapy				
i. Consultation				
(1) Command				
(2) Medical/Surgical activities				
(3) Community organizations				
(4) School				
j. Research				
k. Other *(Specify)*				
Exceptions *(Recommended by Department Chief)*				

DELINEATION OF PRIVILEGES - RADIOLOGY/NUCLEAR MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5504A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, clinical training, demonstrated skills, and capacity to manager procedurally related complications.	APPRD. WITHOUT LIMITATION	APPRD REQUIRES QUAL. SUPRV.	APPRD. WITH MODIFICATIONS	NOT APPRD.
Privileges Requested *(Check)*				
a. Radiology				
b. Diagnostic radiology *(Not qualified to treat diseases with ionizing radiation)*				
c. Diagnostic radiology with special competence in nuclear radiology				
d. Therapeutic radiology *(Not qualified to carry out complicated diagnostic radiologic procedures)*				
e. Nuclear medicine				
Category I. Includes: (1) Practitioners who have completed a minimum of three years of radiology training in an accredited program, not necessarily board certified; and (2) practitioners, even if board certified, who have not received training in a subspecialty area. Under this category the practitioner may practice in an area of subspecialty, but must obtain consultation unless doing so would endanger the survival or well-being of the patient.				
Category II. Includes practitioners who are board certified by the American Board of Radiology or its equivalent or in special instances when they are board eligible. Category II practitioners have not received fellowship training in a subspecialty area such as neuroradiology, but have received limited training during residency. Practitioners who once qualified in Category III, but are no longer clinically active in a particular subspecialty field, will receive Category II privileges. Under this category, practitioners may initiate performance and/or interpretation of subspecialty procedures but must request when the diagnosis is in doubt or if the examination is not successful.				
Category III. Includes practitioners who have specialty board certification granted by the American Board of Radiology or its equivalent and who practice in a subspecialty area that requires completion of a one-year on-the-job training under the supervision of someone qualified in that subspecialty field. Members in this category may perform procedures and interpret them on a full-time basis without outside radiological consultation.				
Subspecialty Areas				
a. Arteriography *(Angiography)*				
b. Ultrasonography to include percutaneous needle biopsies of abdominal organs and cyst punctures				
c. Neuroradiology				
d. Interventional radiology				
e. Computerized tomography				
f. Radioactive isotopes				
g. Other *(Specify)*				
Nuclear Medicine ***(Approved by Radiation Control Committee)***				
a. Diagnostic imaging				
b. Invitro isotope assays				
c. Therapeutic *(Specify isotopes licensed* to use)*				
d. Other *(Specify)*				

* Licensed by a State or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

DELINEATION OF PRIVILEGES - SURGERY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

Eligibility to perform hospital surgical procedures must be based on an individual's education, training, and demonstrated competency. Surgical privileges are divided into four major categories:

Category I. Privileges in this category are for uncomplicated surgical illness or problems which present no serious threat to life. When doubt exists as to the diagnosis or in cases in which improvement from treatment is not soon apparent, consultation will be sought.

Category I privileges may be granted to physicians without formal surgical training based on documented evidence that such privileges have been previously and successfully exercised.

Examples:
- Excision of cyst
- Incision and draining of abscess
- Muscle biopsy
- Evacuation of thrombosed hemorrhoid
- Removal of foreign body by speculum, forceps, or superficial incision
- Suture of laceration *(simple)*
- Excision biopsy of skin or subcutaneous tumor
- Cut down, intravenous or intra-arterial

Other minor conditions and procedures of similar scope and complexity as the above in the surgical specialties.

Category II. Privileges in this category include those in Category I plus specific surgical conditions and procedures of increased scope and complexity and that may require general or conductive anesthesia, but which do not constitute an immediate or serious threat to life. Practitioners with these privileges are expected to request consultation where expected improvement is not soon apparent and when specialized therapeutic or diagnostic techniques are indicated.

Category II privileges may be granted to those practitioners who have satisfactorily completed at least one year post-internship formal training in surgery or whose skills have been gained and maintained through experience.

Examples:
- Breast biopsy
- Hemorrhoidectomy
- Drainage, deep ischio-rectal abscess
- Simple closed fracture management
- Varicose vein ligation *(superficial)*
- Pilonidal cyst excision/marsupialization
- Split thickness skin graft, small areas
- Treatment of closed dislocations

Other specific privileges similar to the above in scope and complexity.

Category III. Privileges in this category include those in Categories I and II plus those associated with complex or severe illness or general surgical problems and those with immediate or serious threat to life. Physicians with these privileges may act as consultants to others and may, in turn, be expected to request consultation when:

a. The diagnosis and/or management remains in doubt over an unduly long period of time, especially in the presence of a life-threatening illness.
b. Unexpected complications arise which are outside this level of competence.
c. Specialized treatments or procedures are contemplated with which they are not familiar.

Category III practitioners are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training and *(except under unusual circumstances as determined by the Credentials Committee)* sufficient to attain eligibility for board certification.

Examples:
- Appendectomy
- Exploratory laparotomy
- Gastic and bowel resection
- Biliary tract surgery
- Abdominoperineal resection
- Lymph node dissection
- Thyroidectomy
- Mastectomy, simple and radical
- Hernia repair *(inguinal, umbilical)*
- Ligation *(high)* stripping of varicose veins
- Wide excision and graft for malignant skin tumor
- Pancreas and spleen surgery
- Diaphragmatic hernia
- Surgery of the adrenal glands
- Sympathectomy
- Cysts and tumors of neck, including salivary glands

Other specific privileges similar to the above in scope and complexity.

Category IV. Privileges in this category include those in Categories I, II, and III to the extent that qualification criteria are met, plus those associated with illnesses and surgical problems requiring an unusual degree of expertise and competence. Practitioners with these privileges have the highest level of competence within a given field and are qualified to act as consultants and should, in turn, request consultation from within or from outside the hospital staff whenever needed.

Practitioners with these privileges are expected to have training and experience considered appropriate for a subspecialist and *(except under unusual circumstances as determined by the Credential Committee)*, sufficient to attain eligibility for subspecialty board certification.

Examples: Surgical subspecialties.

TO PERFORM SURGERY	TO ASSIST AT SURGERY	PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
			APPRD. WITHOUT LIMITATION	QUAL. ASSISTANT REQUIRED	MAY ASSIST ONLY	NOT APPRD.
		a. General surgery				
		b. Cardiac surgery				
		c. Otolaryngology				
		d. Ophthalmology				
		e. Neurosurgery				
		f. Plastic surgery				
		g. Thoracic surgery				
		h. Urology				
		i. Vascular surgery				
		j. Colo-rectal surgery				

TO PERFORM SURGERY	TO ASSIST AT SURGERY	PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF			
			APPRD. WITHOUT LIMITATION	QUAL. ASSISTANT REQUIRED	MAY ASSIST ONLY	NOT APPRD.
		l. 1/Gastrointestinal endoscopy *(Specify type of endoscopic procedures(s))*				
		m. 2/ Diagnostic/therapeutic radiology *(Specify)*				
		Other *(Specify)*				
Category Requested:						
	Category I					
Exceptions (*Recommended by Department Chief*)						
Additional Privileges *(Specify)*						
	Category II					
Exceptions (*Recommended by Department Chief*)						
Additional Privileges *(Specify)*						
	Category III					
Exceptions (*Recommended by Department Chief*)						
Additional Privileges *(Specify)*						
	Category IV					
Exceptions (*Recommended by Department Chief*)						
Additional Privileges *(Specify)*						

1/ Documented and/or demonstrated competence is necessary.
2/ Requires special qualifications of training and experience in equipment use and in the interpretation of results.

DELINEATION OF PRIVILEGES - NURSE ANESTHETISTS

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

	PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF	
	Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
	Clinical Privileges *(Check)*		
	1. Obtain a health history including psychosocial as well as biophysical.		
	2. Conduct physical screening assessment.		
	3. Prescribe TAB approved medications *(attach listing)*.		
	4. Select and administer pre-anesthetic medication *(attach protocol)*.		
	5. Request and evaluate pertinent laboratory studies, pulmonary function studies, including blood gasses, respiratory therapy, and other appropriate studies *(attach protocol)*.		
	6. Insert intravenous catheters, including central venous pressure catheters by basilic vein, external jugular vein, internal jugular vein, subclavian vein *(or other recognized routes of administration)*.		
	7. Insert Swan-Ganz catheters.		
	8. Utilize all current techniques in monitoring.		
	9. Perform regional anesthetic, therapeutic, and diagnostic techniques including but not limited to spinal, epidural, caudal, brachial plexus, transtracheal, superior laryngeal, femoral sciatic, and retrobulbar blocks.		
	10. Select and administer anesthetic techniques, medications and adjunctive drugs *(attach protocol)*.		
	11. Perform intratracheal intubation and extubation		
	12. Identify and manage emergency situations including assessment of adequacy of recovery or antagonism of muscle relaxants, narcotics, and other agents, and implement appropriate management techniques.		
	13. Recognize abnormal patient response to anesthesia or to adjunctive medication and implement corrective action.		
	14. Manage fluid, blood and electrolyte loss and replacement within an anesthesia care plan.		
	15. Initiate and modify therapies, including drug and pain therapy *(attach protocol)*.		
	16. Discharge patients from the Recovery Room *(attach protocol)*.		
	17. Post-anesthesia follow-up and evaluation.		
	18. Initiate cardiopulmonary resuscitation and participate in cardiopulmonary resuscitation in absence of physician *(attach protocol)*.		
	19. Provide consultation, management and implementation of respiratory and ventilatory care.		

DELINEATION OF PRIVILEGES - NURSE MIDWIVES

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
Clinical Privileges *(Check)*		
1. Medical, contraceptive, obstetric, and family history.		
2. Physical examination.		
3. Return prenatal evaluation.		
4. Evaluation and examination for admission to Labor Ward.		
5. Postpartum Ward visits and examinations.		
6. Postpartum Clinic examination.		
7. Family Planning examination.		
8. Interconceptual well-woman gynecologic examination.		
9. Manage the care of normal *(low-risk)* antepartum patients in accordance with Nurse-Midwifery protocols *(attach)*.		
10. Determine need for and manage admission to the Labor Ward.		
11. Manage the care of normal *(low-risk)* labor and delivery per Nurse-Midwifery protocols *(attach)*.		
12. Manage the care and discharge of uncomplicated postpartum patients.		
13. Manage the care of women at the 6-week postpartum visit.		
14. Manage care of women seeking contraceptive advice and interconceptual well-woman gynecologic care.		
15. Prescribe and/or order administer TAB approved medications *(attach listing)*.		
16. Referral to other medical, nursing, or social services.		
17. Orientation to prenatal care.		
18. Preparation for childbirth and breastfeeding.		
19. Postpartum self-care and infant care instruction.		
20. Contraception counseling.		
21. Other *(Specify)*		
Diagnostic Procedures *(Check)*		
1. Clinical pelvimetry.		
2. Pap smear for cytology.		
3. Wet smear and microscopic examination.		
4. Collection of culture specimens for laboratory examination.		
5. Ordering of selected laboratory, X-Ray, and ultrasound studies *(per attached protocols)*.		
6. Conduct and interpret Electronic Fetal Monitoring *(NST, OCT, intrapartum surveillance)*.		
7. Other *(Specify)*		

PRIVILEGES		RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.		APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
Intrapartum Procedures *(Check)*			
	1. Vaginal examinations.		
	2. Start intravenous fluids.		
	3. Amniotomy.		
	4. Placing internal fetal and uterine monitoring devices.		
	5. Augmentation of dysfunctional labor with Oxytocin.		
	6. Local perineal anesthesia.		
	7. Pudendal block.		
	8. Episiotomy and repair *(midline and medio-lateral).*		
	9. Normal spontaneous vaginal delivery from OA or OP positions.		
	10. Cervical inspection.		
	11. Repair lacerations:		
	a. Cervical		
	b. Third degree		
	c. Fourth degree		
	d. Vaginal		
	e. Labial and Periurethral		
	12. Manual removal of placenta.		
	13. Uterine exploration and gauze "curettage".		
	14. Bimanual compression for postpartum hemorrhage.		
Outpatient Procedures *(Check)*			
	1. Select and prescribe oral contraceptives.		
	2. Select and fit cervical diaphragm.		
	3. Select and insert intrauterine contraceptive device for parous women.		
	4. Removal of intrauterine device.		
	5. Treatment of minor gynecologic problems in accordance with Nurse-Midwifery protocols *(attach).*		
Other Procedures *(Specify)*			

DELINEATION OF PRIVILEGES - NURSE PRACTITIONERS *(Adult)*

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
Clinical Privileges *(Check)*		
1. Routine physical examination.		
2. Problem-specific physical examinations.		
3. Prescribe and administer TAB approved medications *(attach listing)*.		
4. Initiate referral to other medical/nursing services.		
5. Health maintenance/disease prevention counseling.		
6. Chronic disease self-management counseling.		
Diagnosis and Treatment *(Check)*		
1. Acute Illnesses *(Attach Protocol(s))*		
a. Back pain.		
b. Otitis external.		
c. Otitis media.		
d. Functional bowel.		
e. Gastroenteritis.		
f. Hiatal hernia/esophageal reflux.		
g. Singultus.		
h. Acute simple gastritis.		
i. Chronic gastritis.		
j. Hemorrhoids.		
k. Constipation.		
l. Diarrhea.		
m. Vaginal Infections.		
n. Trichimonas.		
o. Monilia.		
p. Nonspecific bacterial vaginitis.		
q. Atropic vaginitis.		
r. Cervicitis.		
s. Menstrual cramps.		
t. Hyperventilation.		
u. Acute pneumonia.		
v. Viral infections--respiratory.		
w. Bacterial infections--respiratory.		
x. Viral pharyngitis.		
y. Presumptive strep pharyngitis.		
z. Pharyngitis secondary to PND.		
aa. Exudative tonsillitis.		
bb. Sinusitis.		
cc. Infectious mononucleosis.		

	PRIVILEGES	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
	dd. Influenza.		
	ee. Urinary tract infection.		
	ff. Cystitis.		
	gg. Ingrown toenail.		
	hh. Fungal infection.		
	ii. Common dermatology problems.		
	jj. Sebaceous cyst.		
	kk. Lipoma.		
	ll. Keratitis.		
	mm. Basal cell.		
	nn. Ganglion.		
	oo. Tension headaches.		
	pp. Other *(Specify)*		
	2. Stable Chronic Illnesses *(Attach Protocol(s)).*		
	a. Anemia.		
	b. Angina.		
	c. Chemotherapy.		
	d. Congestive heart failure.		
	e. Chronic obstructive pulmonary disease.		
	f. Diabetes.		
	g. Estrogen therapy.		
	h. Gout.		
	i. Hyperlipoproteinemia.		
	j. Hypertension.		
	k. Hyperthyroidism.		
	l. Hypothyroidism.		
	m. Migraines.		
	o. Obesity.		
	p. Osteoarthritis.		
	q. Osteoporosis.		
	r. Uncomplicated Peptic Ulcer Disease.		
	s. Rheumatoid Arthritis.		
	t. Tuberculosis Prophylaxis.		
	u. Other *(Specify)*		
	Diagnostic Procedures *(Check)*		
	a. Order routine lab tests on blood, secretions, and urine.		
	b. Order selected radiologic studies.		
	c. Order EKGs.		
	d. Collect culture and smear specimens.		
	e. Perform PAP smears.		
	f. Other *(Specify)*		

DELINEATION OF PRIVILEGES - OB/GYN NURSE PRACTITIONER

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
Clinical Privileges *(Check)*		
1. Gynecologic assessment *(pelvic and breast)* with deviations from normal being referred to the physician.		
2. Diagnostic and screening tests.		
3. Uncomplicated obstetrical care *(antepartal, post-partal)*.		
4. Health teaching and counseling regarding maintenance of health, family planning, and preparation for childbirth		
5. Normal newborn care.		
6. Prescribe TAB approved medications *(attach listing)*.		
Diagnostic and Treatment *(Check)*		
1. Cervicitis, erosion, and eversion of cervix.		
2. Vaginitis		
a. Trichomonas.		
b. Monilia		
c. Nonspecific or mixed.		
3. Gonorrhea and those referred as Gonorrhea *(contacts from Health & Environment Division or Public Health Service)*.		
4. Condyloma Accuminata (Venereal warts).		
5. Herpes Simplex of Genitalia		
6. Other *(Specify)*		
Diagnostic Procedures *(Check)*		
1. Pelvic Examination		
2. Pap smear.		
3. Breast examination.		
4. Cryosurgery with appropriate follow-up.		
5. IUD insertion and removal.		
6. Diaphram fitting.		
7. Cervical cultures and wet slides		
8. Ordering of laboratory tests.		
a. Pregnancy tests.		
b. UA, culture and sensitivity		
c. CBC.		
d. Rubella titer.		
e. Blood type and RH factor.		
f. FBS, 2-hour pospradial for diabetic screening.		
g. Vaginal and cervical cultures.		

DELINEATION OF PRIVILEGES - PHYSICIAN ASSISTANTS

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED REQUIRES QUAL. SUPRV. PER AR 40-68	NOT APPROVED
Specialty Areas *(Check)*		
1. Aviation medicine.		
2. Dermatology.		
3. Emergency medicine.		
4. Family practice.		
5. Orthopedics.		
a. Outpatient.		
b. Operating room.		
6. Occupational medicine.		
Non-Specialty Areas *(Check)*		
1. Ambulatory care clinic.		
2. Combat and combat support battalions.		
3. Field medical units.		
4. Troop medical clinic.		
5. Other *(Specify)*		
Clinical Privileges *(Check)*		
1. Patient screening to determine need for medical care.		
2. Supervision of immunizations *(AR 40-562)*.		
3. Nuclear surety evaluations *(AR 40-501)*.		
4. Temporary profiles *(not to exceed 30 days)*.		
5. Diagnose and treat minor illnesses *(referral will be made to a physician for conditions which do not respond to therapy with the first visit or whose cause is not immediately determined)*. Excludes patients returning for treatment of chronic illnesses previously documented in their medical record.		
a. Adult		
b. Adolescent		
c. Pediatric *(over two years of age)*.		
6. Outpatient history and physical examinations.		
7. Prescribe and administer TAB approved medications (attach listing).		
8. Order routine laboratory tests on blood, secretions, and urine.		
9. Order X-rays of chest, abdomen, and extremities which do not require contrast material.		
10. Other *(Specify)*		

PRIVILEGES		RECOMMENDATIONS BY DEPT./SVS. CHIEF	
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.		APPROVED REQUIRES QUAL. SUPRV. PER AR 40-48	NOT APPROVED
Inpatient Clinical Privileges ***(Require Physician Review and Signature) (Check)***			
	1. Admission histories.		
	2. Physical examinations.		
	3. Routine doctor's orders.		
	4. Narrative summaries.		
	5. Other *(Specify)*		
Procedures ***(Check)***			
	1. Wound care, debridement, and suturing of minor lacerations.		
	2. Incision and drainage abscess.		
	3. Urethral catheterization.		
	4. Administer inhalation medications.		
	5. Administer IV fluids to adults.		
	6. Nasogastric and nasopharyngeal intubations.		
	7. Stabilization of fractures.		
	8. Other *(Specify)*		
	9. Anesthesia		
	a. Digital block.		
	b. Intercostal.		
	c. Local.		
Exceptions (Recommended by Department/Clinic Chief)			

DELINEATION OF PRIVILEGES - DIETETICS

For use of this form, see AR 40-68; the proponent agency is OTSG

1. MEDICAL TREATMENT FACILITY			
2. NAME	3. RANK	4. DUTY SSI	
	a. DEGREE	b. INSTITUTION	c. DATE
5. Under-Graduate			
6. Graduate			
7. REGISTRATION NO.		8. MEMBER ADA	
9. POST-GRADUATE SPECIALTY TRAINING		10. PRIVILEGING PERIOD	
		a. FROM	b. TO
		11. REMARKS	

Category I - Routine nutritional assessments and nutritional care procedures expected of registered hospital dietitians. **Category II - Special Privileges:** Require additional skill level demonstrated through additional training and practical expertise *(see item 9 above).*	APPLICANT'S REQUEST		SUPERVISOR'S RECOMMENDATION			CREDENTIAL COMMITTEE'S RECOMMENDATION			
	FULL PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	NOT APPD.
12. Prescribing vitamins.									
13. Prescribing therapeutic nutritional supplements.									
14. Ordering laboratory tests.									
15. Percent body fat testing.									
16. Prescribing diets other than weight control.									

a. SIGNATURE	b. DATE
17. APPLICANT	
18. IMMEDIATE SUPERVISOR	
19.CREDENTIALS COMMITTEE REPRESENTATIVE	

DELINEATION OF PRIVILEGES - OCCUPATIONAL THERAPY

For use of this form, see AR 40-68; the proponent agency is OTSG

1. MEDICAL TREATMENT FACILITY		
2. NAME	3. RANK	4. DUTY SSI

	a. DEGREE	b. INSTITUTION	c. DATE
5. Under-Graduate			
6. Graduate			

7. STATE LICENSURE	8. CERTIFIED AOTA NO.	9. EXPIRATION DATE

10. POST-GRADUATE SPECIALTY TRAINING	11. PRIVILEGING PERIOD	
	a. FROM	b. TO

Category I - General Practice. Occupational therapy prevention, maintenance, and restoration programs for all categories of patients - pediatrics, adolescents, adults. Evaluates, developments treatment plans and implements treatment in regard to occupational performance (e.g., work, leisure, and self-care proficiencies) and performance components which include motor, cognitive, social and psychological function in accordance with the professional standards established by the American Occupational Therapy Assoc. Treatment includes individual and group activities ad education.

SPECIAL PROCEDURES	APPLICANT'S REQUEST		SUPERVISOR'S RECOMMENDATION			CREDENTIAL COMMITTEE'S RECOMMENDATION			
	FULL PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	NOT APPD.
12. Prosthetic checkout and training *(upper extremity).*									
13. Neurodevelopmental treatment for adults.									
14. Percent Body Fat Determination.									
15. Neurodevelopmental treatment of children.									
16. Refer to specialty clinics.									
17. Southern California sensory interpretation testing, administration and interpretation.									

18. REMARKS

	a. SIGNATURE	b. DATE
19. APPLICANT		
20. IMMEDIATE SUPERVISOR		
21. CREDENTIALS COMMITTEE REPRESENTATIVE		

Category II - Neuromusculoskeletal Evaluations. Evaluation and treatment of neuromusculoskeletal complaints of the upper extremity under AR 40-48 *(Non-Physician Health Care Providers).* General privileges include: Collection of historical data regarding nature of current complaint; conducting evaluation of upper extremity; requesting routine laboratory studies; authenticating temporary profiles either assigning or removing duty limitations *(not to exceed 30 days).* Requesting routine referrals to appropriate specialty clinics; prescribing non-legend medication *(betadine, korles, ace bandages);* and providing treatment in clinic, TMC or peripheral unit.

SPECIAL PROCEDURES	APPLICANT'S REQUEST		SUPERVISOR'S RECOMMENDATION			CREDENTIAL COMMITTEE'S RECOMMENDATION			
	FULL PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	NOT APPD.
22. Order and read hand, wrist, forearm, arm and glenohumeral joint X-rays.									
23. Cast/splinting of fractures, contusions, strains and sprains.									
24. Suture removal.									
25. Wound care, dressing and changing.									
26. Assist with closed reduction of routine fractures and dislocations of the hand and wrist.									
27. Request EMG, NCV, and MCV studies of major nerves of the upper extremity.									
28. Write prescriptions for analgesic and non-steroidal/ASA compound anti-inflammatory medication. *(TAB-approved list attached.)*									
29. Other *(Specify)*									

30. REMARKS

DELINEATION OF PRIVILEGES - PHYSICAL THERAPY

For use of this form, see AR 40-68; the proponent agency is OTSG

1. MEDICAL TREATMENT FACILITY		
2. NAME	3. RANK	4. DUTY MOS

	a. DEGREE	b. INSTITUTION	c. DATE
5. Under-Graduate			
6. Graduate			

7. STATE LICENSURE	8. CERTIFIED APTA NO.
9. POST-GRADUATE SPECIALTY TRAINING	10. PRIVILEGING PERIOD
	a. FROM / b. TO

Category I - Routine physical therapy evaluations and procedures expected of graduate physical therapist. **Category II - Special Privileges.** Require additional skill level demonstrated through additional training and practical expertise *(see item 9 above).*	APPLICANT'S REQUEST		SUPERVISOR'S RECOMMENDATION			CREDENTIAL COMMITTEE'S RECOMMENDATION			
	FULL PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	FULL PRIV.	TEMP. PRIV.	COND. PRIV.	NOT APPD.
11. Electromyographic testing.									
12. Nerve conduction velocity testing.									
13. Inhibitive casting.									
14. Percent body fat testing.									
15. Early intervention hi-risk infants.									
Category III - Neuromusculoskeletal Evaluations.									
16. Request X-rays.									
17. Temporary profile not exceeding 30 days.									
18. Assign quarters up to 72 hours.									
19. Refer to specialty clinics.									
20. Medication prescription *(see attachment).*									
Category IV - Other Privileges (List below).									

21. REMARKS

	a. SIGNATURE	b. DATE
22. APPLICANT		
23. IMMEDIATE SUPERVISOR		
24. CREDENTIALS COMMITTEE REPRESENTATIVE		

DELINEATION OF PRIVILEGES

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

1. SPECIALTY	
2. REQUESTED BY	3. DATE

4. PRIVILEGES	5. RECOMMENDATIONS BY DEPT./SVS. CHIEF			
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED

DELINEATION OF PRIVILEGES - EMERGENCY MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

REQUESTED BY	DATE

Assignment of clinical privileges will be based on education, clinical training, experience and demonstrated competence.

Check appropriate category and desired privileges.

	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED	NOT APPRD/LACK MTF/MSN SUPPORT
Category I. Is partially or fully trained in the specialty or has acquired skills in the specialty through interest and experience. May provide consultations and supervise trainees but will obtain consultation before treating all but routine conditions or performing other than simple diagnostic or therapeutic procedures.					
a. Minor lacerations					
b. Minor respiratory illness; ENT illness.					
c. Minor gastrointestinal illness.					
d. Minor burns.					
e. Minor musculoskeletal trauma.					
f. Minor dermotologic illness without systemic involvement.					
g. Minor GYN problems excluding gravid patients.					
h. Detection of major abnormalities on X-rays.					
i. Peripheral intravenous access.					
Category II. Board certified or eligible for certification, or fulfilling a practice time requirement established by the specialty board for gaining certification. May act independently in most circumstances, provide consultations, and supervise trainees. However, will seek advice and consultation on complex cases.					
a. Major lacerations involving more than one layer of closure.					
b. Acute respiratory illnesses including acute respiratory failure in the ER setting.					
c. Gunshot wounds or knife injuries excluding chest or neck.					
d. Acute cardiac emergencies including cardiac failure, myocardial infarction, and cardiac arrhythmias.					
e. Poisoning.					
f. Near drowning.					
g. Arthrocentesis.					
h. Thermal injuries and possible related inhalation injury.					
i. Patients with altered consciousness.					
j. Management of routine ER administrative matters.					
k. Severe head and neck trauma					
l. Minor abscesses, thrombosed hemorrhoids, infected ingrown nails.					
m. Caustic ingestions.					
n. Chemical or nuclear injury.					
o. Management of rape or sexual assault victims.					
p. Initial management of suspected cervical spine injury.					
q. Placement of nasogastric tubes.					
r. Acute psychiatric illness, suicidal patients.					
s. Alcohol and drug overdose and withdrawal syndromes.					
t. Multiple trauma victims.					
u. Critically burned patient.					

Assignment of clinical privileges will be based on education, clinical training, experience and demonstrated competence. Check appropriate category and desired privileges.	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED	NOT APPRD/LACK MTF/MSN SUPPORT
v. Animal and human bites.					
w. Eye trauma or illness					
x. Uncomplicated pneumothorax *(with or without tension)*					
y. Acute compartment compression syndrome.					
z. Use of lumbar puncture as diagnostic technique.					
aa. Use of MAST device in hypotensive patients.					
Category III. Competent in all Category II privileges. The staff member must have been certified by the specialty board or have equivalency by virtue of training and experience. Acts independently in directing patient care, providing consultations, and supervising other practitioners subject to peer review.					
a. Airway maintenance including emergency crico-thyreotomy and nasotracheal and orotracheal intubation.					
b. Transvenous and transthoracic cardiac pacemaker placement.					
c. Placement of arterial monitoring devices.					
d. Paracentesis.					
e. Thoracentesis and placement of thoracostomy tube with intrathoracic suction.					
f. Reduction of fracture dislocations which offer neurovascular compromise.					
g. Central venous catheter placement.					
h. Pericardiocentesis.					
i. Use of ventilator (mechanical) and application of arterial and venous blood gas data to the use of the same.					
j. Prehospital radio communications, EMT SOPs.					
k. Peritoneal lavage.					
l. Be familiar with, by recall, the ER Policy Manual.					
m. For full certification in this category, applicant should have 3,000 hours ER experience. If not, indicate approximate number of hours:					
(1) 0 - 1,000					
(2) 1,000 - 2,000					
(3) 2,000					
Category IV. Extensive relevant training or experience beyond board certification.					
a. Competent in Categories, I, II, and III.					
b. In the absence of immediate consultant care, the surgical management of leaking or ruptured thoracic aneurysm in life-threatening situation, inclusive of emergency thoracostomy and cross-clamping of the aorta, open cardiac massage, but not inclusive of bypass techniques or definitive repair.					
c. In the absence of consultant care, the surgical management of through-and-through wounds to the chest not inclusive of bypass techniques or definitive repair.					
d. Have management experience or documented training in triage supervision in mass casualty.					
e. In the absence of consultant, be familiar with ER techniques for evaluation of acute subdural hematomas and able to use this knowledge.					

Assignment of clinical privileges will be based on education, clinical training, experience and demonstrated competence. Check appropriate category and desired privileges.	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFI-CATIONS	NOT APPROVED	NOT APPRD/LACK MTF/MSN SUPPORT
Other					
(1) Currently certified in BCLS.					
(2) Currently certified in ACLS.					
(3) Currently certified in ATLS.					
(4) Prescribe schedule IV drugs, as appropriate.					
(5) Prescribe schedule III drugs, as appropriate.					
(6) Prescribe schedule II drugs, as appropriate.					
Category I, II, III, IV *(Identify category).*					
Exceptions *(Other than above). (Specify)*					
Additional Privileges *(Specify)*					

DELINEATION OF PRIVILEGES - AVIATION MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

CHECK ONE ☐ AC ☐ USAR ☐ ARNG

REQUESTED BY

DATE

Aviation Medicine is to promote aviation safety and prevent illness and injury of Army aviators and aviation support personnel; provide medical support in selection personnel for aviation-related training; make recommendations regarding continued utilization of aviation personnel who may develop physical disabilities.

Practitioners will demonstrate skills in interviewing, examination, assessment, and management of patients with general medicine, obstetrical, surgical and psychiatric health problems. Seriously ill patients will be managed in consultation with or direct referral to specialty physicians.

Note: Aviation Medicine clinical privileges are divided into the four Family Practice categories. ***DA Form 5440-2-R (Delineation of Privileges - Family Practice) will be completed and attached to this form.***

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Check aviation medicine specific privileges below.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
☐ Perform physical examinations to aid in the selection of personnel who are physically and psychologically fit for flying, and who can be expected to remain fit throughout an entire career.					
☐ Evaluation of, monitoring of, and protection from psycho-physiological stresses of the flight environment.					
☐ Aeromedical investigation of the causes and results of aircraft accidents and incidents, with the goal of preventing future similar accidents and injuries.					
☐ Aeromedical staff duties, including being on the personal special staff of the aviation unit commander as primary medical, advisor, participating in the unit safety programs, acting as a member of Flight Evaluation Boards, supervision of fitting and use of personal lift support equipment, and supervision/coordination of hospital and or installation aeromedical activities as appropriate.					
☐ Participation on a regular basis in operational flights, field problems, and missions of aviation units assigned to post.					
☐ Interview newly assigned flight personnel, and review their health records; interview and review health records of downed personnel, before granting a medical clearance for flying *(DA Form 4186)*.					
ADDITIONS *(Specify)*					
EXCEPTIONS *(Recommended by Department Chief)*					

☐ DA Form 5440-2-R completed and attached.

DA FORM 5440-24-R, JUL 89

DELINEATION OF PRIVILEGES - GENERAL MEDICAL OFFICER

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

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REQUESTED BY

DATE

Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated skills in interviewing, examination, assessment, and management of patients with general medical, obstetrical, surgical, and psychiatric problems.

Consultation will be obtained from specialists before initiating elective care of patients with serious or complicated illnesses or major injuries. In an emergency, will do all in his or her power to save life or prevent disability, to include calling for available consultations.

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Check desired privileges below.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
1. **Physical evaluation.** History and physical examination to include vaginal and rectal.					
2. **Diagnostic tests.** Order and initially interpret ECG; order laboratory tests on blood, urine, and secretions and radiologic tests *(including contrast material)* which do not require hospitalization; basic initial radiographic interpretations *(skull, spine, chest, abdomen and extremities).*					
3. **Medication.** Initiate drug therapy for acute and chronic common illnesses not requiring hospitalization, and continue therapy in followup of conditions where therapy was initiated by a consultant.					
4. **Procedures.** Excision of superficial skin subcutaneous lesions for pathologic study, suture of minor lacerations (except eyelids), I&D simple abscesses, cast simple fractures, aspirate or inject joints, and lumbar punctures, as applicable to the clinic setting.					
a. Basic cardiac life support.					
b. Advanced cardiac life support.					
c. Emergency airway management, basic.					
d. Emergency airway management, advanced.					
e. Cannulation and gastric lavage.					
5. Admission of patients to a specialty service.					
6. Treatment of ARD inpatients.					
7. Familiarity with regulations regarding reportable diseases; e.g., venereal, hepatitis.					
8. Triage and management of mass casualty situations.					
9. Profiling officer IAW AR 40-501 (*Temporary Profile*).					
ADDITIONS ***(Specify)***					
EXCEPTIONS ***(Recommended by Department Chief)***					

DA FORM 5440-25-R, JUL 89

DELINEATION OF PRIVILEGES - TROOP MEDICAL CLINIC PHYSICIANS

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

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REQUESTED BY

DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
General.					
1. Diagnose and treat acute minor illness.					
2. Prescribe routine medications.					
3. Administration of medication *(excluding I.V. meds, except emergency).*					
4. Administration of I.V. fluids and referral.					
5. Routine cultures.					
6. Local anesthesia.					
7. Digital block anesthesia.					
8. Repair of simple lacerations.					
9. Removal of foreign bodies from soft tissue which are exposed and/or superficial in nature.					
10. Skin and superficial lacerations.					
11. Basic life support, cardiopulmonary resuscitation.					
12. Advanced cardiopulmonary resuscitation.					
13. Initial interpretation of X-rays.					
Internal Medicine.					
1. Electrocardiograph, initial interpretation.					
2. Pneumothorax, emergency treatment.					
Dermatology.					
KOH Prep.					
Gynecology.					
1. Pelvic bimanual exam, Pap smear, breast exam.					
2. Treatment of pelvic inflammatory disease, nonsurgical with consultation.					
3. Prescribing of oral contraceptives.					
4. Removal of IUD.					
General Surgery.					
1. Incision and drainage, simple abscess.					
2. Incision and drainage of external thrombotic hemorrhoid, pilonidal cyst, followed by referral.					
Orthopedic Surgery.					
1. Initial and emergency management of trauma, minor or major, pending transfer.					
2. Suturing of minor digital and extremity lacerations not involving nerve, tendon or vessel repair.					
3. Nonsurgical management of back and neck pain.					
4. Initial management and care of closed fracture *(including casting)* followed by referral.					
a. Hand and wrist.					
(1) Nondisplaced fracture, closed management, followed by referral.					

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
Orthopedic Surgery *(Continued)*.					
b. Forearm and shoulder girdle: Nondispatched fractures, closed management followed by referral.					
c. Knee: nondisplaced, followed by referral.					
d. Management and care of closed fracture *(including casting)*.					
(1) Foot: Ingrown toe nail, management.					
(2) Ankle: Severe sprain, closed management followed by referral.					
EENT.					
1. Treatment of anterior nose bleeds.					
2. Packing of posterior nose bleeds and stat referral.					
3. Minor EENT problems, i.e., otitis media, tonsillitis, conjunctivitis, sinusitis.					
Psychiatry/Neurology.					
1. Neurological examination.					
2. Psychotherapeutic medication prior to transfer to Acute Care facility.					
3. Immediate crisis interaction pending referral.					
Genitourinary.					
1. Management of minor GU problems.					
2. Catheterization followed by referral.					
Opthalmology.					
1. Removal of loose foreign body.					
2. Removal of imbedded corneal surface foreign body.					
Optometry.					
1. Eye examination *(routine)*.					
Emergency Medicine.					
1. Administration of emergency I.V. fluids.					
2. Administration of emergency I.V. medications.					
3. Tube Thoracostomy, emergency.					
4. Cricothyroidotomy, emergency.					
5. Endotracheal intubation, emergency.					
6. Basic life support, cardiopulmonary resuscitation.					
7. Advanced cardiopulmonary resuscitation.					
8. Gastric lavage.					
EXCEPTIONS *(Specify)*					
ADDITIONAL PRIVILEGES *(Specify)*					

DELINEATION OF PRIVILEGES - TROOP MEDICAL CLINIC DENTISTS - GENERAL DENTISTRY

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

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REQUESTED BY

DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
1. **Diagnostic:** All procedures except-- 00310 Sialography 00450 Macroscopic tissue examination 00451 Microscopic tissue examination					
2. **Preventive:** All procedures.					
3. **Restorative:** All procedures except-- 02400 *(Series)* Gold foil restorations 02500 *(Series)* Cast inlay restorations 02600 *(Series)* Porcelain restorations					
4. **Endodontics:** All procedures except-- 03350 Apexification/Specification treatment 03410 Apicoectomy 03420 Retrograde filling 03480 Pneumatization 03960 Bleaching discolored teeth 03970 Perforation repair 03980 Endodontic endosseus implant 03981 Endodontic internal splint					
5. **Peridontics:** Only-- 04321 Provisional splint, extracoronal 04330 Occlusal adjustment, limited 04342 Peridontal scaling 04343 Peridontal scaling and root planning 04351 Root desensitation					
6. **Removable Prostholdontics:** Only-- 05611 Complete denture repair 05621 Partial denture repair 05810 Denture temporary - Maxillary 05811 Denture temporary - Mandibular					
7. **Fixed Prosthodontics:** Only-- 06600 (Series) Repairs 06711 Acrylic resin interim (Prefabricated) 06712 Acrylic resin interim (Autopolyminizing) 06718 Dowel & Core, metal 06709 Stain;less steel, aluminum, interim					
8. **Oral Surgery:** Only-- 07110 Tooth removal 07120 Tooth removal, complicated 07140 Tooth replantation 07210 Repair traumatic wounds, simple (Under 5 cm) 07320 Alveoloplasty 07511 Incision and drainage 07811 Reduction of dislocation 07901 Postsurgical treatment 07902 Osteitis treatment					
9. **Adjunctive General Services:** All procedures except-- 09924 Diagnostic mounting 09925 Mandibular recording 09940 Mouth protectors 09941 Resin stints 09942 Flouride carriers 09943 Radiation shield 09944 Radiation needle carrier 09220 General anesthesia 09231 Intravenous sedation or analgesia 09232 Intramuscular sedation or analgesia 09233 Inhalation sedation or analgesia 09234 Oral sedation or analgesia 09235 Hypnosis 09610 Therapeutic medication by injection 09700 (Series) hospital services 09771 Hyperbaric monitoring					
ADDITIONAL PRIVILEGES *(Specify)*					
EXCEPTIONS *(Specify)*					

DA FORM 5440-26-2-R, JUL 89

DELINEATION OF PRIVILEGES - TROOP MEDICAL PHYSICIAN ASSISTANTS

For use of this form, see AR 40-68; the proponent agency is OTSG

(DA Form 5440A-R Must be Completed and Attached to this Form)

CHECK ONE ☐ AC ☐ USAR ☐ ARNG

REQUESTED BY

DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
General.					
1. Diagnose and treat acute minor illness.					
2. Prescribe routine medications.					
3. Administration of medication *(excluding I.V. meds, except emergency).*					
4. Administration of I.V. fluids and referral.					
5. Routine cultures.					
6. Local anesthesia.					
7. Digital block anesthesia.					
8. Repair of simple lacerations.					
9. Removal of foreign bodies from soft tissue which are exposed and/or superficial in nature.					
10. Skin and superficial lacerations.					
11. Basic life support, cardiopulmonary resuscitation.					
12. Advanced cardiopulmonary resuscitation.					
13. Initial interpretation of X-rays.					
Internal Medicine.					
1. Electrocardiograph, initial interpretation.					
2. Pneumothorax, emergency treatment.					
Dermatology.					
KOH Prep.					
Gynecology.					
1. Pelvic bimanual exam, Pap smear, breast exam.					
2. Treatment of pelvic inflammatory disease, nonsurgical with consultation.					
3. Prescribing of oral contraceptives.					
4. Removal of IUD.					
General Surgery.					
1. Incision and drainage, simple abscess.					
2. Incision and drainage of external thrombotic hemorrhoid, pilonidal cyst, followed by referral.					
Orthopedic Surgery.					
1. Initial and emergency management of trauma, minor or major, pending transfer.					
2. Suturing of minor digital and extremity lacerations not involving nerve, tendon or vessel repair.					
3. Nonsurgical management of back and neck pain.					
4. Initial management and care of closed fracture *(including casting)* followed by referral.					
a. Hand and wrist.					
(1) Nondisplaced fracture, closed management, followed by referral.					

REQUESTED BY	DATE

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Assignment of clinical privileges will be based on education, clinical training, experience, and demonstrated competence.	APPROVED WITHOUT LIMITATION	APPROVED REQUIRES QUAL. SUPRV.	APPROVED WITH MODIFICATIONS	NOT APPROVED	NOT APPD. LACK OF MTF/MSN SUPPORT
Orthopedic Surgery *(Continued)*.					
b. Forearm and shoulder girdle: Nondispatched fractures, closed management followed by referral.					
c. Knee: nondisplaced, followed by referral.					
d. Management and care of closed fracture *(including casting)*.					
(1) Foot: Ingrown toe nail, management.					
(2) Ankle: Severe sprain, closed management followed by referral.					
EENT.					
1. Treatment of anterior nose bleeds.					
2. Packing of posterior nose bleeds and stat referral.					
3. Minor EENT problems, i.e., otitis media, tonsillitis, conjunctivitis, sinusitis.					
Psychiatry/Neurology.					
1. Neurological examination.					
2. Psychotherapeutic medication prior to transfer to Acute Care facility.					
3. Immediate crisis interaction pending referral.					
Genitourinary.					
1. Management of minor GU problems.					
2. Catheterization followed by referral.					
Opthalmology.					
1. Removal of loose foreign body.					
2. Removal of imbedded corneal surface foreign body.					
Optometry.					
1. Eye examination *(routine)*.					
Emergency Medicine.					
1. Administration of emergency I.V. fluids.					
2. Administration of emergency I.V. medications.					
3. Tube Thoracostomy, emergency.					
4. Cricothyroidotomy, emergency.					
5. Endotracheal intubation, emergency.					
6. Basic life support, cardiopulmonary resuscitation.					
7. Advanced cardiopulmonary resuscitation.					
8. Gastric lavage.					
EXCEPTIONS *(Specify)*					
ADDITIONAL PRIVILEGES *(Specify)*					

EVALUATION OF PRIVILEGES - ANESTHESIA

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD		DATE
FROM	TO	

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
Category II.					
Category III.					
a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures.					
b. The support of life functions under the stress of anesthetic and surgical manipulations.					
c. The clinical management of the patient unconscious from whatever cause.					
d. The management of problems in pain relief.					
e. The management of problems in cardiac and respiratory resuscitation.					
f. The application of specific methods of respiratory therapy.					
g. The clinical management of various fluid, electrolyte, and metabolic disturbances.					
TYPE PATIENT					
a. Adult					
b. Pediatric					
c. Newborn					
d. Obstetrical Only					
TYPE ANESTHESIA					
a. General					
b. Regional					
(1) Spinal					
(2) Epidural					
(3) Caudal/Pudendal					
(4) Nerve Block					
(5) Auxiliary Blocks					
(6) Intravenous *(Bier-Block)*					
SPECIAL PROCEDURES					
a. Arterial Pressure Lines					
b. Central Venous Pressure Line					
c. Swan-Ganz Catheter					
d. Arterial/Venous Puncture					
e. Hypothermia					
f. Other *(Specify)* →					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I - Dental Hygienists					
Category II - Dental Therapy Assistants *(DTA)*					
Category III - General Dentists *(63A)*					
Category IV - Specialists					
SPECIALTIES (Check specialty area for privileges performed)					
a. Preventive Dentistry/Dental Public Health *(63H)*					
b. Oral Medicine and Oral Pathology *(63C, 63P)*					
c. Pedodontics *(63K)*					
d. Orthodontics *(63M)*					
e. Prosthodontics, Fixed *(63F)*					
f. Proshodontics, Removable *(63G)*					
g. Periodontics *(63D)*					
h. Endodontics *(63E)*					
i. General Dentistry *(63B)*					
j. Oral Surgery *(63N)*					
f. Other Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

EVALUATION OF PRIVILEGES - DENTISTRY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I - General Dentists *(63A)*					
Category II - Specialists					
SPECIALTIES ***(Check specialty area for privileges performed)***					
a. General Dentistry *(63B)*					
b. Periodontics *(63D)*					
c. Endodontics *(63E)*					
d. Prosthodontics *(63F)*					
e. Dental public health *(63H)*					
f. Pediatric Dentestry *(63K)*					
d. Orthodontics *(63M)*					
j. Oral Surgery *(63N)*					
k. Oral Pathology *(63P)*					
f. Other Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

SUPERVISOR'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - FAMILY PRACTICE

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
PROCEDURES/SKILLS ***(Check Privileges Performed)***					
a. Proctosigmoidoscopy					
b. ECG Performance and Initial Interpretations					
c. Basic Radio Interpretations *(Skull, spine, CXR, abdomen, IVP, and extremity)*					
d. Insertion/Removal of IUD					
e. Regional Anesthesia					
f. Splinting/Casting/Immobilizing of Simple Fractures					
g. Other *(Specify)*					
Category II.					
PROCEDURES/SKILLS ***(Check Privileges Performed)***					
a. Lumbar Puncture *(Adult and Child)*					
b. Infant/Newborn Resuscitation					
c. Vaginal Delivery *(Uncomplicated)*					
d. Endometrial Biopsy					
e. Other *(Specify)*					
Category III.					
PROCEDURES/SKILLS ***(Check Privileges Performed)***					
a. Joint Aspiration/Injection					
b. Diagnostic Thoracentesis With or Without Biopsy					
c. Abdominal Pericentesis					
d. Bone Marrow Aspiration and Biopsy					
e. Low Forceps Delivery					
f. Vacuum Extraction					
g. Obstetrical Anesthesia					
h. Culdocentesis					
i. Dilation & Curettage					
j. First Assist at Major Surgical Procedures					
k. Flexible Sigmoidoscopy					
l. Reduction of Simple Fractures of Extremities					
j. Vasectomy					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category III *(Continued).*					
ADDITIONAL PRIVILEGES *(Specify)*					
EXCEPTIONS *(Recommended by Department Chief)*					
Category IV.					
PROCEDURES/SKILLS *(Check Privileges Performed)*					
a. Swan-Ganz Catherization					
b. Management of Severe Pre-eclampsia					
c.					
d.					
e.					
f.					
ADDITIONAL PRIVILEGES *(Specify)*					
EXCEPTIONS *(Recommended by Department Chief)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

EVALUATION OF PRIVILEGES - INTERNAL MEDICINE AND SUBSPECIALTY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
CLINICAL AREAS. ***(Write I, II, III, or IV to Indicate the Category or Privileges In Each Area That You Are Requesting Privileges.)***					
a. Allergy-Immunology					
b. Cardiology					
c. Dermatology					
d. Endoctrine and metabolic diseases					
e. Gastroenterology					
f. Hematology					
g. Infectious disease					
h. Internal medicine					
i. Nephrology					
j. Pulmonary disease					
k. Rheumatology					
l. Oncology					
SPECIAL PROCEDURES ***(Check the Procedures for Which Privileges are Requested and Attach a Statement Indicating Your Qualifications to Perform Each of Them.)***					
Special Studies, Invasive					
a. Arterial puncture and cannulation					
b. Angiography, cerebral					
c. Arteriography					
d. Arthrocentesis					
e. Bronchial brushing					
f. Bronchial lavage					
g. Bronchograms					
h. Bone marrow aspiration					
i. Cardiac Catherization					
j. Cardiac pacemaker *(Transvenous)*					
k. Cholangiography, percutaneous					
l. Cisternal Tap					
m. Hemodialysis					
n. Hemofiltration					
o. Lymphangiography					
p. Myelography					
q. Paracentesis, abdominal					
r. Pericardiocentesis					
s. Peritoneal dialysis					
t. Phlebography					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Special Studies, Invasive *(Continued)*					
u. Plasmaphoresis					
v. Pneumoencephalography					
w. Spinal tap					
x. Subclavian puncture					
y. Swan-Ganz catherization					
z. Thoracentesis					
Other *(Specify)*					
Biopsy and Excision. Needle Biopsy of:					
a. Bone Marrow					
b. Kidney					
c. Liver					
d. Lung					
e. Thyroid					
f. Pericardial biopsy *(Closed)*					
g. Peritoneal biopsy *(Closed)*					
h. Pleural biopsy *(Closed)*					
i. Skin biopsy					
j. Small intestinal biopsy with Crosby capsule & Shiner tube					
Other *(Specify)*					
Endoscopy					
a. Bronchoscopy					
b. Colonoscopy					
c. Duodenoscopy					
d. Esophagoscopy					
e. Mediastinoscopy					
f. Peritoneoscopy					
g. Sigmoidoscopy					
Other *(Specify)*					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

	PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
	Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
	Special Studies, Non-Invasive and Other Procedures					
	a. Echocardiography					
	b. ECG interpretation					
	c. Electroconvulsant therapy					
	d. EEG interpretation					
	e. Electromyography					
	f. Endotracheal intubation					
	g. Other intubation *(Specify)*					
	h. Esophageal dilatation					
	i. Hypnosis					
	j. Peripheral vascular studies *(Non-Invasive)*					
	k. Phonocardiography					
	l. Pulmonary function interpretation					
	m. Radioactive isotopes, diagnostic					
	n. Radioactive isotopes, therapeutic					
	o. Vectorcardiography interpretation					
	p. Respirator management					
	q. Diagnostic/Therapeutic radiology *(Specify)*					
	Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

EVALUATION OF PRIVILEGES - NEUROLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I. Emergency Care Uncomplicated illnesses or problems which have low risk to the patient such as recurrent headache or uncomplicated epilepsy or with no available treatment such as completed ischemic stroke, progressive dementia in the elderly, and cerebral palsy. Internists, pediatricians, family practitioners, and psychiatrists where neurology training has been included in their residency experience.					
Category II. Category I Major illnesses, injuries, conditions or procedures with little immediate risk to life, in child or adult such as multiple sclerosis, Parkinson's disease, and transient ischemic attacks. Management of crippling or life threatening disorder where category III and IV supervisor is available. Performance of EMG, EEG, evoked potentials and similar tests for which the applicant has had specific training. One year of general postgraduate education and two years of specialty training in adult or child neurology.					
Category III. Categories I and II Management of all conditions affecting the nervous system in adults except for those patients requiring neurosurgical intervention. Management of common non-life threatening conditions in children. Completion of neurology training in adult neurology.					
Category IV. Categories I, II, and III Management of all neurologic conditions affecting children except those children requiring neurological intervention (child neurology). Diagnosis and management of refractory seizure disorders, unusual neuromuscular disorders or other problems reflecting additional subspecialty skills. Individual patients display complexity exceeding those of Category III. Require post residency fellowships or child neurology residency/fellowship.					
SPECIAL PROCEDURES.					
a. Lumbar Puncture					
b. Cisternal Tap					
c. Subdural Tap *(Infants)*					
d. Electroencephalogram *(EEG)*					
e. Brain Stem Auditory Evoked Response					
f. Visual Evoked Response					
g. Somatosensory Evoked Response					
h. Electromyogram *(EMG)*					
i. Myelogram					
Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)* *(Use reverse if needed.)*

SUPERVISOR'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - OBSTETRICS AND GYNECOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Check category *(level)* of performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
a. Emergency care					
b. Normal antepartum and postpartum care					
c. Normal labor and delivery					
d. Maternal-fetal monitoring					
e. Episiotomy and repair of second degree laceration					
f. Local infiltration anesthesia					
g. Pudendal block anesthesia					
h. Use of oxytocic drugs after completion of third stage					
i. Sigmoidoscopy					
Category II.					
a. Cervical dilation and curettage *(including vacuum)*					
b. Biopsy of cervix, endometrium, or vulva					
c. Abdominal salpingo-oopherectomy, ovarian cystectomy					
d. Abdominal tubal interruption					
e. Incidental appendectomy					
f. Amniocentesis					
g. Repair of third and fourth degree lacerations					
h. Drainage/marsupialization of bartholin cyst					
i. Fetal scalp sampling					
j. Neonatal resuscitation					
k. Neonatal resuscitation					
l. Elective low forceps					
m. Manual removal of placeenta and postpartum uterine exploration					
n. Circumcision of newborn					
Category III.					
a. Hysterosalpingography					
b. Hysteroscopy					
c. Laparoscopy, diagnostic and operative					
d. Ureteroscopy and cystoscopy					
e. Supraclavicular or other superficial node biopsy					
f. Abdominal hysterectomy					
g. Partial omentectomy					
h. Myomectomy and uterine plastic procedures					
i. Urethrovesical suspension					
j. Repair of cystocele and rectocele					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category III *(Continued).*					
k. Repair of injury to bladder					
l. Vaginal hysterectomy					
m. Vaginal tubal interruption					
n. Cervical conization					
o. Cervical cerclage					
p. All vaginal deliveries					
q. All Caeserean deliveries					
r. Intrauterine radioactive source applications					
s. Venous catheter insertion					
t. Paracervical anesthesia					
u. Tubal reconstructive procedures not using microsurgery					
Category IV.					
a. Extirpative and reconstructive gynecologic surgery, including radical hysterectomy, vulvectomy, Lymph-adenectomy, and exenteration					
b. Surgical repair of injury to bowel, ureter, and pelvic vessels					
c. Bowel resection and bypass					
d. Bowel-urinary conduits					
e. Tubal reconstructive procedures using microsurgery					
f. Urodynamic examination					
g. Colposcopy					
h. Obstetric ultrasound imaging					
i. Intra-amniotic operative procedures					
j. Surgical application of lasers					
k. Placement of intra-arterial catheter					
l. Regional anesthesia					
CATEGORY I, II, III, IV *(Identify Category)*					
ADDITIONAL PRIVILEGES *(Specify)*					
COMMENTS *(Borderline and unacceptable ratings will be addressed.)*					

SUPERVISOR'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - OPTOMETRY SERVICE

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL EDUCATION	SELDOM EXER-CISED
Category I. Privileges in this category are for uncomplicated illnesses, injuries, or routine procedures which may require diagnostic drugs. When doubt exists as to the diagnosis or in cases in which improvement is not soon apparent, consultation will be sought.					
Category II. Privileges include Category I, plus practitioners may evaluate, diagnose and treat difficult and complex vision//eye disorders. May act as consultants but are expected to request consultation when: (1) The diagnosis and/or management remains in doubt over an unduly long period of time; (2) Unexpected complications arise which are outside this level of competence; (3) specialized treatment measures are contemplated with which they are not familiar.					
Category III Privileges include those in Categories I and II to the extent that qualification criteria are met, plus those associated with illnesses or problems requiring an unusual degree of expertise and competence. Practitioners with their privileges have the highest level of competence within a given field and are qualified to act as consultant but will request consultation when needed.					
OTHER PRIVILEGES *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)* ***(Use additional sheet if needed.)***

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PATHOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL EDUCATION	SELDOM EXER-CISED
AREAS OF ANATOMIC AND CLINICAL PATHOLOGY ***(Write Category I, II, or III to Indicate Level of Privileges Being Evaluated.)***					
Anatomic Pathology					
a. Surgical Pathology					
b. Autopsy Pathology					
c. Cytopathology					
d. Neuropathology					
e. Dermatopathology					
f. Electron Microscopy					
g. Immunohistology					
h. Forensic Pathology					
ADDITIONS ***(Specify)***					
Clinical Pathology					
a. Clinical Chemistry					
b. Hematopathology					
c. Immunohistology					
d. Blood Banking					
e. Clinical Microscopy					
f. Microbiology					
g. Radioisotopic Pathology					
h. Serology					
ADDITIONS ***(Specify)***					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PEDIATRICS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM TO

DATE

RATED BY

TITLE

PRIVILEGES PERFORMED BY

TREATMENT FACILITY

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I. Emergency Care. Supervision and care of routine term newborns and uncomplicated pediatric patients; i.e., illnesses, injuries, conditions or procedures which have low risk to the patient.					
PROCEDURES					
a. Venipuncture					
b. Lumbar puncture					
c. Urethral catheterization					
d. Incision and drainage of abscess					
e. Other *(Specify)*					
Category II. Category I Major illnesses, injuries, conditions or procedures but with no significant risk to life.					
PROCEDURES					
a. Subdural taps on infants with open fontanelle					
b. Pleuracentesis					
c. Peritoneal tap					
d. Saphenous or antecubital vein cutdowns					
e. Arterial puncture					
f. Intubations					
(1) Oro-trachael					
(2) Naso-tracheal intubation					
g. Suprapubic puncture					
h. Insertion of chest tube					
i. Exchange transfusion					
j. Sigmoidoscopy					
k. Proctoscopy					
l. Pre-oral biopsy					
m. Skin biopsy					
n. Other *(Specify)*					
Category III. Categories I and II Major illnesses, injuries, conditions, or procedures which carry substantial threat to life.					
PROCEDURES					
a. Lung puncture					
b. Cardioversion					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category III. ***(Continued)***					
c. Pericardiocentesis					
d. Bone marrow aspiration					
e. Bone marrow biopsy					
f. Administration of chemotherapy					
(1) Systematic chemotherapy					
(2) Intrathecal chemotherapy					
g. Endoscopy					
k. Intestinal biopsy					
l. Other *(Specify)*					
Category IV. Categories I, II, and III Unusually complex or critical illnesses, injuries, conditions or procedures which carry a serious threat to life.					
PROCEDURES					
a. Bronchoscopy					
b. Pleural biopsy					
c. Lung biopsy, closed					
d. Cardiac catheterization					
e. Angiography					
f. Lymphangiography					
g. Kidney biopsy					
k. Bone marrow transplantation					
l. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PODIATRY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
Category II.					
Category III.					
AREAS OF FOOT PATHOLOGY ***(Check Category I, II, or III for Privileges Being Evaluated.)***					
a. General Practice					
b. Foot Surgery					
(1) Common Surgical Procedures on Forefoot					
(2) Complex Reconstructive Surgery					
c. Podiatric Dermatology					
d. Foot Orthopedics					
e. Podopediatrics					
f. Podogeriatrics					
g. X-Ray Services *(Interpretation)*					
h. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PSYCHIATRY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
Category II.					
Category III.					
Category IV. ***(Check Subspecialty.)***					
a. Child Psychiatry					
b. Psychoanalysis					
c. Child Psychoanalysis					
d. Forensic Psychiatry					
e. Administrative Psychiatry					
f. Geriatric Psychiatry					
g. Consultant-Liaison Psychiatry					
h. Psychosomatic Medicine					
Other *(Specify)*					
Privileges Performed ***(Check)***					
a. Assessment and Diagnosis of Mental Disorders					
b. Inpatient Psychiatric Treatment					
c. Alcohol/Drug Residential Treatment					
d. Adult Psychotherapy					
(1) Individual					
(2) Marital					
(3) Family					
(4) Group					
e. Child and Adolescent Psychiatry					
(1) Assessment and Diagnosis					
(2) Psychotherapy					
(a) Family					
(b) Group					
(3) Psychopharmacotherapy					
f. Somatic Therapy					
(1) Psychopharmacotherapy					
(2) Biofeedback Therapy					
(3) Electro-Convulsive Therapy					
(4) Amytal Interview					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Privileges Performed ***(Continued) (Check)***					
g. Consultation					
(1) Command					
(2) Medical/Surgical Activities					
(3) Community Organizations					
(4) School					
h. Specialized Skills					
(1) Forensic Psychiatry					
(2) Psychoanalysis					
(3) Child Psychoanalysis					
(4) Geriatric Psychiatry					
(5) Behavior Therapy					
(6) Gestalt Therapy					
(7) Hypnotherapy					
Other *(Specify)*					
i. Research					
j. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PSYCHOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
Category II.					
Category III.					
Category IV.					
Privileges Performed (*Check*)					
a. Assessment in psychological diagnosis					
b. Assists in inpatient management of mental disorders					
c. Psychological assistance in alcohol/drug residential treatment					
d. Outpatient psychological treatment					
e. Psychotherapy					
(1) Psychoanalytical oriented psychotherapy (*Individual*)					
(2) Behavior therapy					
(3) Gestalt therapy					
(4) Hypnotherapy					
(5) Transactional analysis					
(6) Group therapy					
(7) Marital therapy					
(8) Family therapy					
(9) Sexual dysfunction therapy					
(10) Psychosomatic therapy					
(11) Brief therapy					
f. Child psychotherapy					
g. Adolescent psychotherapy					
h. Somatic psychotherapy					
(1) Biofeedback therapy					
(2) Hypnotherapy					
i. Consultation					
(1) Command					
(2) Medical/Surgical activities					
(3) Community organizations					
(4) School					
j. Research					
k. Other (*Specify*)					

COMMENTS (*Borderline and unacceptable ratings will be addressed.*) (*Use reverse side if needed.*)

EVALUATION OF PRIVILEGES - RADIOLOGY/NUCLEAR MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Privileges Performed ***(Check)***					
a. Radiology					
b. Diagnostic radiology *(Not qualified to treat diseased with ionizing radiation)*					
c. Diagnostic radiology with special competence in nuclear radiology					
d. Therapeutic radiology *(Not qualified to carry out complicated diagnostic radiologic procedures)*					
e. Nuclear medicine					
Performance Level ***(Check)***					
Category I.					
Category II.					
Category III.					
Subspecialty Areas					
a. Arteriography *(Angiography)*					
b. Ultrasonography to include percutaneous needle biopsies of abdominal organs and cyst punctures					
c. Neuroradiology					
d. Interventional radiology					
e. Computerized tomography					
f. Radioactive isotopes					
g. Other *(Specify)*					
Nuclear Medicine ***(Approved by Radiation Control Committee)***					
a. Diagnostic imaging					
b. Invitro isotope assays					
c. Therapeutic *(Specify isotopes licensed to use)*					
d. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse side if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - SURGERY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
SPECIALTIES/SUBSPECIALTIES. *Identify level of performance with an "A" for Assist and a "P" for Perform in block.)*					
a. General surgery					
b. Cardiac surgery					
c. Otolaryngology					
d. Ophthalmology					
e. Neurosurgery					
f. Plastic surgery					
g. Thoracic surgery					
h. Urology					
i. Vascular surgery					
j. Colo-rectal surgery					
l. Gastrointestinal endoscopy *(Specify type of endoscopic procedures(s))*					
m. Diagnostic/therapeutic radiology *(Specify)*					
Other *(Specify)*					
Category *(Check Performance Level)*					
Category I					
Additional Privileges Performed *(Specify)*					
Category II					
Additional Privileges Performed *(Specify)*					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category ***(Check Performance Level) (Continued)***					
Category III					
Additional Privileges Performed ***(Specify)***					
Category IV					
Additional Privileges Performed ***(Specify)***					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - NURSE ANESTHETISTS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	DATE
FROM TO	

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Clinical Privileges *(Check)*					
1. Obtain a health history including psychosocial as well as biophysical.					
2. Conduct physical screening assessment.					
3. Prescribe TAB approved medications *(attach listing).*					
4. Select and administer pre-anesthetic medication *(attach protocol).*					
5. Request and evaluate pertinent laboratory studies, pulmonary function studies, including blood gasses, respiratory therapy, and other appropriate studies *(attach protocol).*					
6. Insert intravenous catheters, including central venous pressure catheters by basilic vein, external jugular vein, internal jugular vein, subclavian vein *(or other recognized routes of administration).*					
7. Insert Swan-Ganz catheters.					
8. Utilize all current techniques in monitoring.					
9. Perform regional anesthetic, therapeutic, and diagnostic techniques including but not limited to spinal, epidural, caudal, brachial plexus, transtracheal, superior laryngeal, femoral sciatic, and retrobulbar blocks.					
10. Select and administer anesthetic techniques, medications and adjunctive drugs *(attach protocol).*					
11. Perform intratracheal intubation and extubation					
12. Identify and manage emergency situations including assessment of adequacy of recovery or antagonism of muscle relaxants, narcotics, and other agents, and implement appropriate management techniques.					
13. Recognize abnormal patient response to anesthesia or to adjunctive medication and implement corrective action.					
14. Manage fluid, blood and electrolyte loss and replacement within an anesthesia care plan.					
15. Initiate and modify therapies, including drug and pain therapy *(attach protocol).*					
16. Discharge patients from the Recovery Room *(attach protocol).*					
17. Post-anesthesia follow-up and evaluation.					
18. Initiate cardiopulmonary resuscitation and participate in cardiopulmonary resuscitation in absence of physician *(attach protocol).*					
19. Provide consultation, management and implementation of respiratory and ventilatory care.					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - NURSE MIDWIVES

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Clinical Privileges *(Check)*					
1. Medical, contraceptive, obstetric, and family history.					
2. Physical examination.					
3. Return prenatal evaluation.					
4. Evaluation and examination for admission to labor ward.					
5. Postpartum ward visits and examinations.					
6. Postpartum clinic examination.					
7. Family planning examination.					
8. Interconceptual well-woman gynecologic examination.					
9. Manage the care of normal *(low-risk)* antepartum patients in accordance with nurse-midwifery protocols *(attach)*.					
10. Determine need for and manage admission to the Labor Ward.					
11. Manage the care of normal *(low-risk)* labor and delivery per nurse-midwifery protocols *(attach)*.					
12. Manage the care and discharge of uncomplicated postpartum patients.					
13. Manage the care of women at the 6-week postpartum visit.					
14. Manage care of women seeking contraceptive advice and interconceptual well-woman gynecologic care.					
15. Prescribe and/or order administer TAB approved medications *(attach listing)*.					
16. Referral to other medical, nursing, or social services.					
17. Orientation to prenatal care.					
18. Preparation for childbirth and breastfeeding.					
19. Postpartum self-care and infant care instruction.					
20. Contraception counseling.					
21. Other *(Specify)*					
Diagnostic Procedures *(Check)*					
1. Clinical pelvimetry.					
2. Pap smear for cytology.					
3. Wet smear and microscopic examination.					
4. Collection of culture specimens for laboratory examination.					
5. Ordering of selected laboratory, X-Ray, and ultrasound studies *(per attached protocols)*.					
6. Conduct and interpret Electronic Fetal Monitoring *(NST, OCT, intrapartum surveillance)*.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Intrapartum Procedures *(Check)*					
1. Vaginal examinations.					
2. Start intravenous fluids.					
3. Amniotomy.					
4. Placing internal fetal and uterine monitoring devices.					
5. Augmentation of dysfunctional labor with Oxytocin.					
6. Local perineal anesthesia.					
7. Pudendal block.					
8. Episiotomy and repair *(midline and medio-lateral).*					
9. Normal spontaneous vaginal delivery from OA or OP positions.					
10. Cervical inspection.					
11. Repair lacerations:					
a. Cervical					
b. Third degree					
c. Fourth degree					
d. Vaginal					
e. Labial and Periurethral					
12. Manual removal of placenta.					
13. Uterine exploration and gauze "curettage".					
14. Bimanual compression for postpartum hemorrhage.					
Outpatient Procedures *(Check)*					
1. Select and prescribe oral contraceptives.					
2. Select and fit cervical diaphragm.					
3. Select and insert intrauterine contraceptive device for parous women.					
4. Removal of intrauterine device.					
5. Treatment of minor gynecologic problems in accordance with Nurse-Midwifery protocols *(attach).*					
Other Procedures *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - NURSE PRACTITIONERS *(Adult)*

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Clinical Privileges *(Check)*					
1. Routine physical examination.					
2. Problem-specific physical examinations.					
3. Prescribe and administer TAB approved medications *(attach listing).*					
4. Initiate referral to other medical/nursing services.					
5. Health maintenance/disease prevention counseling.					
6. Chronic disease self-management counseling.					
Diagnosis and Treatment *(Check)*					
1. Acute Illnesses					
a. Back pain.					
b. Otitis external.					
c. Otitis media.					
d. Functional bowel.					
e. Gastroenteritis.					
f. Hiatal hernia/esophageal reflux.					
g. Singultus.					
h. Acute simple gastritis.					
i. Chronic gastritis.					
j. Hemorrhoids.					
k. Constipation.					
l. Diarrhea.					
m. Vaginal Infections.					
n. Trichimonas.					
o. Monilia.					
p. Nonspecific bacterial vaginitis.					
q. Atropic vaginitis.					
r. Cervicitis.					
s. Menstrual cramps.					
t. Hyperventilation.					
u. Acute pneumonia.					
v. Viral infections--respiratory.					
w. Bacterial infections--respiratory.					
x. Viral pharyngitis.					
y. Presumptive strep pharyngitis.					
z. Pharyngitis secondary to PND.					
aa. Exudative tonsillitis.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
1. Acute Illnesses *(Continued).*					
bb. Sinusitis.					
cc. Infectious mononucleosis.					
dd. Influenza.					
ee. Urinary tract infection.					
ff. Cystitis.					
gg. Ingrown toenail.					
hh. Fungal infection.					
ii. Common dermatology problems.					
jj. Sebaceous cyst.					
kk. Lipoma.					
ll. Keratitis.					
mm. Basal cell.					
nn. Ganglion.					
oo. Tension headaches.					
pp. Other *(Specify)*					
2. Stable Chronic Illnesses					
a. Anemia.					
b. Angina.					
c. Chemotherapy.					
d. Congestive heart failure.					
e. Chronic obstructive pulmonary disease.					
f. Diabetes.					
g. Estrogen therapy.					
h. Gout.					
i. Hyperlipoproteinemia.					
j. Hypertension.					
k. Hyperthyroidism.					
l. Hypothyroidism.					
m. Migraines.					
o. Obesity.					
p. Osteoarthritis.					
q. Osteoporosis.					
r. Uncomplicated Peptic Ulcer Disease.					
s. Rheumotoid Arthritis.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
2. Stable Chronic Illnesses *(Continued)*.					
t. Tuberculosis Prophylaxis.					
u. Other *(Specify)*					
Diagnostic Procedures *(Check)*					
a. Order routine lab tests on blood, secretions, and urine.					
b. Order selected radiologic studies.					
c. Order EKGs.					
d. Collect culture and smear specimens.					
e. Perform PAP smears.					
f. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - OB/GYN NURSE PRACTITIONER

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Clinical Privileges *(Check)*					
1. Gynecologic assessment *(pelvic and breast)* with deviations from normal being referred to the physician					
2. Diagnostic and screening tests					
3. Uncomplicated obstetrical care *(antepartal, post-partal)*					
4. Health teaching and counseling regarding maintenance of health, family planning, and preparation for childbirth					
5. Normal newborn care					
6. Prescribe TAB approved medications *(attach listing)*					
Diagnostic and Treatment *(Check)*					
1. Cervicitis, erosion, and eversion of cervix					
2. Vaginitis					
a. Trichomonas					
b. Monilia					
c. Nonspecific or mixed					
3. Gonorrhea and those referred as gonorrhea *(contacts from Health & Environment Division or Public Health Service)*					
4. Condyloma accuminata *(Venereal warts)*					
5. Herpes simplex of genitalia					
6. Other *(Specify)*					
Diagnostic Procedures *(Check)*					
1. Pelvic Examination					
2. Pap smear					
3. Breast examination					
4. Cryosurgery with appropriate follow-up					
5. IUD insertion and removal					
6. Diaphram fitting.					
7. Cervical cultures and wet slides					
8. Ordering of laboratory tests					
a. Pregnancy tests.					
b. UA, culture and sensitivity					
c. CBC.					
d. Rubella titer					
e. Blood type and RH factor					
f. FBS, 2-hour postprandial for diabetic screening					
g. Vaginal and cervical cultures					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PHYSICIAN ASSISTANTS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	DATE
FROM TO	

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Clinical Privileges *(Check)*					
1. Patient screening to determine need for medical care.					
2. Supervision of immunizations *(AR 40-562)*.					
3. Nuclear surety evaluations *(AR 40-501)*.					
4. Temporary profiles *(not to exceed 30 days)*.					
5. Diagnose and treat minor illnesses *(referral will be made to a physician for conditions which do not respond to therapy with the first visit or whose cause is not immediately determined)*. Excludes patients returning for treatment of chronic illnesses previously documented in their medical record.					
a. Adult					
b. Adolescent					
c. Pediatric *(over two years of age)*.					
6. Outpatient history and physical examinations.					
7. Prescribe and administer TAB approved medications *(attach listing)*.					
8. Order routine laboratory tests on blood, secretions, and urine.					
9. Order X-rays of chest, abdomen, and extremities which do not require contrast material.					
10. Other *(Specify)*					
Inpatient Clinical Privileges *(Check)*					
1. Admission histories.					
2. Physical examinations.					
3. Routine doctor's orders.					
4. Narrative summaries.					
5. Other *(Specify)*					
Procedures *(Check)*					
1. Wound care, debridement, and suturing of minor lacerations.					
2. Incision and drainage abscess.					
3. Urethral catheterization.					
4. Administer inhalation medications.					
5. Administer IV fluids to adults.					
6. Nasogastric and nasopharyngeal intubations.					
7. Stabilization of fractures.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
8. Other *(Specify)*					
9. Anesthesia					
a. Digital block.					
b. Intercostal.					
c. Local.					
Exceptions *(Recommended by Department/Clinic Chief)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use attitional sheet if needed.)*

EVALUATION OF PRIVILEGES - DIETETICS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	DATE
FROM TO	

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES		RECOMMENDATIONS BY DEPT./SVS. CHIEF				
ITEM		ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.						
Category II.						
	1. Prescribing vitamins.					
	2. Prescribing therapeutic nutritional supplements.					
	3. Ordering laboratory tests.					
	4. Percent body fat testing.					
	5. Prescribing diets other than weight control.					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - OCCUPATIONAL THERAPY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I					
Special Procedures					
1. Prosthetic checkout and training *(upper extremity).*					
2. Neurodevelopmental treatment for adults.					
3. Percent body fat determination.					
4. Neurodevelopmental treatment of children.					
5. Refer to specialty clinics.					
6. Southern California sensory interpretation testing, administration and interpretation.					
Category II					
Special Procedures					
1. Order and read hand, wrist, forearm, arm and glenohumeral joint X-rays.					
2. Cast/splinting of fractures, contusions, strains and sprains.					
3. Suture removal.					
4. Wound care, dressing and changing.					
5. Assist with closed reduction of routine fractures and dislocations of the hand and wrist.					
6. Request EMG, NCV, and MCV studies of major nerves of the upper extremity.					
7. Write prescriptions for analgesic and non-steroidal/ASA compound anti-infammatory medication. *(TAB-approved list attached.)*					
8. Other *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - PHYSICAL THERAPY

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD		DATE
FROM	TO	

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES		RECOMMENDATIONS BY DEPT./SVS. CHIEF				
	ITEM	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
	Category I.					
	Category II.					
	Procedures/Skills.					
	11. Electromyographic testing.					
	12. Nerve conduction velocity testing.					
	13. Inhibitive casting.					
	14. Percent body fat testing.					
	15. Early intervention hi-risk infants.					
	Category III - Neuromusculoskeletal Evaluations.					
	Procedures/Skills.					
	16. Request X-rays.					
	17. Temporary profile not exceeding 30 days.					
	18. Assign quarters up to 72 hours.					
	19. Refer to specialty clinics.					
	20. Medication prescription *(see attachment).*					
	Category IV - Other Privileges *(List below).*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	SPECIALTY

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL EDUCATION	SELDOM EXER-CISED

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - EMERGENCY MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category I.					
a. Minor lacerations					
b. Minor respiratory illness; ENT illness.					
c. Minor gastrointestinal illness.					
d. Minor burns.					
e. Minor musculoskeletal trauma.					
f. Minor dermotologic illness without systemic involvement.					
g. Minor GYN problems excluding gravid patients.					
h. Detection of major abnormalities on X-rays.					
i. Peripheral intravenous access.					
Category II.					
a. Major lacerations involving more than one layer of closure.					
b. Acute respiratory illnesses including acute respiratory failure in the ER setting.					
c. Gunshot wounds or knife injuries excluding chest or neck.					
d. Acute cardiac emergencies including cardiac failure, myocardial infarction, and cardiac arrhythmias.					
e. Poisoning.					
f. Near drowning.					
g. Arthrocentesis.					
h. Thermal injuries and possible related inhalation injury.					
i. Patients with altered consciousness.					
j. Management of routine ER administrative matters.					
k. Severe head and neck trauma					
l. Minor abscesses, thrombosed hemorrhoids, infected ingrown nails.					
m. Caustic ingestions.					
n. Chemical or nuclear injury.					
o. Management of rape or sexual assault victims.					
p. Initial management of suspected cervical spine injury.					
q. Placement of nasogastric tubes.					
r. Acute psychiatric illness, suicidal patients.					
s. Alcohol and drug overdose and withdrawal syndromes.					
t. Multiple trauma victims.					
u. Critically burned patient.					
v. Animal and human bites.					
w. Eye trauma or illness					
x. Uncomplicated pneumothorax *(with or without tension)*					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY TITLE	PRIVILEGES PERFORMED BY	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category II *(Continued).*					
y. Acute compartment compression syndrome.					
z. Use of lumbar puncture as diagnostic technique.					
aa. Use of MAST device in hypotensive patients.					
Category III.					
a. Airway maintenance including emergency cricothyreotomy and nasotracheal and orotracheal intubation.					
b. Transvenous and transthoracic cardiac pacemaker placement.					
c. Placement of arterial monitoring devices.					
d. Paracentesis.					
e. Thoracentesis and placement of thoracostomy tube with intrathoracic suction.					
f. Reduction of fracture dislocations which offer neurovascular compromise.					
g. Central venous catheter placement.					
h. Pericardiocentesis.					
i. Use of ventilator (mechanical) and application of arterial and venous blood gas data to the use of the same.					
j. Prehospital radio communications, EMT SOPs.					
k. Peritoneal lavage.					
l. Be familiar with, by recall, the ER Policy Manual.					
m. For full certification in this category, applicant should have 3,000 hours ER experience. If not, indicate approximate number of hours:					
(1) 0 - 1,000					
(2) 1,000 - 2,000					
(3) 2,000					
Category IV.					
a. Competent in Categories, I, II, and III.					
b. In the absence of immediate consultant care, the surgical management of leaking or ruptured thoracic aneurysm in life-threatening situation, inclusive of emergency thoracostomy and cross-clamping of the aorta, open cardiac massage, but not inclusive of bypass techniques or definitive repair.					
c. In the absence of consultant care, the surgical management of through-and-through wounds to the chest not inclusive of bypass techniques or definitive repair.					
d. Have management experience or documented training in triage supervision in mass casualty.					
e. In the absence of consultant, be familiar with ER techniques for evaluation of acute subdural hematomas and able to use this knowledge.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Category IV *(Continued).*					
f. Other					
(1) Currently certified in BCLS.					
(2) Currently certified in ACLS.					
(3) Currently certified in ATLS.					
(4) Prescribe schedule IV drugs, as appropriate.					
(5) Prescribe schedule III drugs, as appropriate.					
(6) Prescribe schedule II drugs, as appropriate.					
Additional Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use additional sheet if needed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - AVIATION MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Check aviation medicine specific privileges below.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED

Clinical Areas: Identify the level of performance with an **"A"** for **Assist** and a **"P"** for **Perform** in blank space at left.

Note: Aviation Medicine clinical privileges are divided into the four Family Practice categories. ***DA Form 5440-2-R (Delineation of Privileges - Family Practice) will be completed and attached to this form.***

	1. Perform physical examinations to aid in the selection of personnel who are physically and psychologically fit for flying, and who can be expected to remain fit throughout an entire career.					
	2. Evaluation of, monitoring of, and protection from psycho-physiological stresses of the flight environment.					
	3. A meromedical investigation of the causes and results of aircraft accidents and incidents, with the goal of preventing future similar accidents and injuries.					
	4. Aeromedical staff duties, including being on the personal special staff of the aviation unit commander as primary medical, advisor, parti-cipating in the unit safety programs, acting as a member of Flight Evaluation Boards, supervision of fitting and use of personal lift support equipment, and supervision/coordination of hospital and or installation aeromedical activities as appropriate.					
	5. Participation on a regular basis in operational flights, field problems, and missions of aviation units assigned to post.					
	6. Interview newly assigned flight personnel, and review their health records; interview and review health records of downed personnel, before granting a medical clearance for flying *(DA Form 4186).*					
	Other Privileges ***(Specify)***					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

☐ DA Form 5440-2-R completed and attached.

EVALUATION OF PRIVILEGES - GENERAL MEDICAL OFFICER

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD FROM	TO	DATE

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL EDUCATION	SELDOM EXER-CISED
Clinical Areas: Identify the level of performance with an **"A"** for **Assist** and a **"P"** for **Perform** in the blank space at left. **Note:** Aviation Medicine clinical privileges are divided into the four Family Practice categories. ***DA Form 5440-2-R (Delineation of Privileges - Family Practice) will be completed and attached to this form.***					
1. **Physical evaluation.** History and physical examination to include vaginal and rectal.					
2. **Diagnostic tests.** Order and initially interpret ECG; order laboratory tests on blood, urine, and secretions and radiologic tests *(including contrast material)* which do not require hospitalization; basic initial radiographic interpretations *(skull, spine, chest, abdomen and extremities).*					
3. **Medication.** Initiate drug therapy for acute and chronic common illnesses not requiring hospitalization, and continue therapy in followup of conditions where therapy was initiated by a consultant.					
4. **Procedures.** Excision of superficial skin subcutaneous lesions for pathologic study, suture of minor lacerations (except eyelids), I&D simple abscesses, cast simple fractures, aspirate or inject joints, and lumbar punctures, as applicable to the clinic setting.					
a. Basic cardiac life support.					
b. Advanced cardiac life support.					
c. Emergency airway management, basic.					
d. Emergency airway management, advanced.					
e. Cannulation and gastric lavage.					
5. Admission of patients to a specialty service.					
6. Treatment of ARD inpatients.					
7. Familiarity with regulations regarding reportable diseases; e.g., venereal, hepatitis.					
8. Triage and management of mass casualty situations.					
9. Profiling officer IAW AR 40-501 *(Temporary Profile).*					
Other Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

DA FORM 5441-25-R, JUL 89

EVALUATION OF PRIVILEGES - TROOP MEDICAL CLINIC PHYSICIANS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	CHECK ONE
FROM TO	☐ AC ☐ USAR ☐ ARNG

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE	DATE	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Clinical Areas: Identify the level of performance with an **"A"** for **Assist** and a **"P"** for **Perform** in the blank space at left.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
General.					
1. Diagnose and treat acute minor illness.					
2. Prescribe routine medications.					
3. Administration of medication *(excluding I.V. meds, except emergency).*					
4. Administration of I.V. fluids and referral.					
5. Routine cultures.					
6. Local anesthesia.					
7. Digital block anesthesia.					
8. Repair of simple lacerations.					
9. Removal of foreign bodies from soft tissue which are exposed and/or superficial in nature.					
10. Skin and superficial lacerations.					
11. Basic life support, cardiopulmonary resuscitation.					
12. Advanced cardiopulmonary resuscitation.					
13. Initial interpretation of X-rays.					
Internal Medicine.					
1. Electrocardiograph, initial interpretation.					
2. Pneumothorax, emergency treatment.					
Dermatology.					
KOH Prep.					
Gynecology.					
1. Pelvic bimanual exam, Pap smear, breast exam.					
2. Treatment of pelvic inflammatory disease, nonsurgical with consultation.					
3. Prescribing of oral contraceptives.					
4. Removal of IUD.					
General Surgery.					
1. Incision and drainage, simple abscess.					
2. Incision and drainage of external thrombotic hemorrhoid, pilonidal cyst, followed by referral.					
Orthopedic Surgery.					
1. Initial and emergency management of trauma, minor or major, pending transfer.					
2. Suturing of minor digital and extremity lacerations not involving nerve, tendon or vessel repair.					
3. Nonsurgical management of back and neck pain.					
4. Initial management and care of closed fracture *(including casting)* followed by referral.					
a. Hand and wrist.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY TITLE	PRIVILEGES PERFORMED BY	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Clinical Areas: Identify the level of performance with an "A" for **Assist** and a "P" for **Perform** in the blank space at left.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Orthopedic Surgery *(Continued)*.					
(1) Nondisplaced fracture, closed management, followed by referral.					
b. Forearm and shoulder girdle: Nondispatched fractures, closed management followed by referral.					
c. Knee: nondisplaced, followed by referral.					
d. Management and care of closed fracture *(including casting).*					
(1) Foot: Ingrown toe nail, management.					
(2) Ankle: Severe sprain, closed management followed by referral.					
EENT.					
1. Treatment of anterior nose bleeds.					
2. Packing of posterior nose bleeds and stat referral.					
3. Minor EENT problems, i.e., otitis media, tonsillitis, conjunctivitis, sinusitis.					
Psychiatry/Neurology.					
1. Neurological examination.					
2. Psychotherapeutic medication prior to transfer to Acute Care facility.					
3. Immediate crisis interaction pending referral.					
Genitourinary.					
1. Management of minor GU problems.					
2. Catheterization followed by referral.					
Opthalmology.					
1. Removal of loose foreign body.					
2. Removal of imbedded corneal surface foreign body.					
Optometry.					
1. Eye examination *(routine).*					
Emergency Medicine.					
1. Administration of emergency I.V. fluids.					
2. Administration of emergency I.V. medications.					
3. Tube Thoracostomy, emergency.					
4. Cricothyroidotomy, emergency.					
5. Endotracheal intubation, emergency.					
6. Basic life support, cardiopulmonary resuscitation.					
7. Advanced cardiopulmonary resuscitation.					
8. Gastric lavage.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Other Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.)*

RATER'S SIGNATURE	DATE

EVALUATION OF PRIVILEGES - TROOP MEDICAL CLINIC DENTISTS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	CHECK ONE
FROM TO	☐ AC ☐ USAR ☐ ARNG

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE	DATE	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
1. **Diagnostic:** All procedures except-- 00310 Sialography 00450 Macroscopic tissue examination 00451 Microscopic tissue examination					
2. **Preventive:** All procedures.					
3. **Restorative:** All procedures except-- 02400 *(Series)* Gold foil restorations 02500 *(Series)* Cast inlay restorations 02600 *(Series)* Porcelain restorations					
4. **Endodontics:** All procedures except-- 03350 Apexification/Specification treatment 03410 Apicoectomy 03420 Retrograde filling 03480 Pneumatization 03960 Bleaching discolored teeth 03970 Perforation repair 03980 Endodontic endosseus implant 03981 Endodontic internal splint					
5. **Peridontics:** Only-- 04321 Provisional splint, extracoronal 04330 Occlusal adjustment, limited 04342 Peridontal scaling 04343 Peridontal scaling and root planning 04351 Root desensitization					
6. **Removable Prosthodontics.** Only-- 05611 Complete denture repair 05621 Partial denture repair 05810 Denture temporary - Maxillary 05811 Denture temporary - Mandibular					
7. **Fixed Prostholdontics:** Only-- 06600 (Series) Repairs 06711 Acrylic resin interim (Prefabricated) 06712 Acrylic resin interim (Autopolyminizing) 06718 Dowel & Core, metal 06709 Stain;less steel, aluminum, interim					
8. **Oral Surgery:** Only-- 07110 Tooth removal 07120 Tooth removal, complicated 07140 Tooth replantation 07210 Repair traumatic wounds, simple (Under 5 cm) 07320 Alveoloplasty 07511 Incision and drainage 07811 Reduction of dislocation 07901 Postsurgical treatment 07902 Osteitis treatment					
9. **Adjunctive General Services:** All procedures except-- 09924 Diagnostic mounting 09925 Mandibular recording 09940 Mouth protectors 09941 Resin stints 09942 Flouride carriers 09943 Radiation shield 09944 Radiation needle carrier 09220 General anesthesia 09231 Intravenous sedation or analgesia 09232 Intramuscular sedation or analgesia 09233 Inhalation sedation or analgesia 09234 Oral sedation or analgesia 09235 Hypnosis 09610 Therapeutic medication by injection 09700 (Series) hospital services 09771 Hyperbaric monitoring					
Additional Privileges *(Specify)*					

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

DA FORM 5441-26-2-R, JUL 89

EVALUATION OF PRIVILEGES - TROOP MEDICAL CLINICAL PHYSICIAN ASSISTANTS

For use of this form, see AR 40-68; the proponent agency is OTSG

PERIOD	CHECK ONE
FROM TO	☐ AC ☐ USAR ☐ ARNG

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE	DATE	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Clinical Areas: Identify the level of performance with an "A" for **Assist and** and a "P" for Perform in the blank space at left.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
General.					
1. Diagnose and treat acute minor illness.					
2. Prescribe routine medications.					
3. Administration of medication *(excluding I.V. meds, except emergency).*					
4. Administration of I.V. fluids and referral.					
5. Routine cultures.					
6. Local anesthesia.					
7. Digital block anesthesia.					
8. Repair of simple lacerations.					
9. Removal of foreign bodies from soft tissue which are exposed and/or superficial in nature.					
10. Skin and superficial lacerations.					
11. Basic life support, cardiopulmonary resuscitation.					
12. Advanced cardiopulmonary resuscitation.					
13. Initial interpretation of X-rays.					
Internal Medicine.					
1. Electrocardiograph, initial interpretation.					
2. Pneumothorax, emergency treatment.					
Dermatology.					
KOH Prep.					
Gynecology.					
1. Pelvic bimanual exam, Pap smear, breast exam.					
2. Treatment of pelvic inflammatory disease, nonsurgical with consultation.					
3. Prescribing of oral contraceptives.					
4. Removal of IUD.					
General Surgery.					
1. Incision and drainage, simple abscess.					
2. Incision and drainage of external thrombotic hemorrhoid, pilonidal cyst, followed by referral.					
Orthopedic Surgery.					
1. Initial and emergency management of trauma, minor or major, pending transfer.					
2. Suturing of minor digital and extremity lacerations not involving nerve, tendon or vessel repair.					
3. Nonsurgical management of back and neck pain.					
4. Initial management and care of closed fracture *(including casting)* followed by referral.					
a. Hand and wrist.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY TITLE	PRIVILEGES PERFORMED BY	

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Clinical Areas: Identify the level of performance with an "A" for **Assist and** and a "P" for Perform in the blank space at left.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Orthopedic Surgery *(Continued)*.					
(1) Nondisplaced fracture, closed management, followed by referral.					
b. Forearm and shoulder girdle: Nondispatched fractures, closed management followed by referral.					
c. Knee: nondisplaced, followed by referral.					
d. Foot: Ingrown toe nail, management.					
e. Ankle: Severe sprain, closed management followed by referral.					
EENT.					
1. Treatment of anterior nose bleeds.					
2. Packing of posterior nose bleeds and stat referral.					
3. Minor EENT problems, i.e., otitis media, tonsillitis, conjunctivitis, sinusitis.					
Psychiatry/Neurology.					
1. Neurological examination.					
2. Psychotherapeutic medication prior to transfer to Acute Care facility.					
3. Immediate crisis interaction pending referral.					
Genitourinary.					
1. Management of minor GU problems.					
2. Catheterization followed by referral.					
Opthalmology.					
1. Removal of loose foreign body.					
2. Removal of imbedded corneal surface foreign body.					
Optometry.					
1. Eye examination *(routine)*.					
Emergency Medicine.					
1. Administration of emergency I.V. fluids.					
2. Administration of emergency I.V. medications.					
3. Tube Thoracostomy, emergency.					
4. Cricothyroidotomy, emergency.					
5. Endotracheal intubation, emergency.					
6. Basic life support, cardiopulmonary resuscitation.					
7. Advanced cardiopulmonary resuscitation.					
8. Gastric lavage.					

PERIOD FROM TO	DATE	TREATMENT FACILITY
RATED BY	PRIVILEGES PERFORMED BY	
TITLE		

PRIVILEGES		RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance. Clinical Areas: Identify the level of performance with an **"A"** for **Assist and** and a **"P"** for Perform in the blank space at left.		ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
Other Privileges *(Specify)*						

COMMENTS *(Borderline and unacceptable ratings will be addressed.) (Use reverse if needed.)*

RATER'S SIGNATURE	DATE

USAR OR ARNG APPLICATION FOR CLINICAL PRIVILEGES TO PERFORM ACTIVE OR INACTIVE DUTY TRAINING

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10, USC, Section 1071

Principal Purpose: To define the extent and limits of the practitioner's clinical privileges as a function of his or her training experience.

Routine Uses: Determine and assess capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hospitals, the Federation of State Medical Boards of the U.S., State Licensure authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY NO. *(SSN)*	3. DOB	4. GRADE

5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING

SECTION B - BASIC INFORMATION

8. LICENSURE/CERT.		9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure *(If any)*			
b. DEA Number *(If any)*			
c. CPR Certificate			
d. ACLS Certificate			
e. BCLS Certificate			

11. BOARD ELIGIBLE FROM *(Date)*	12a. BOARD EXAM TAKEN *(Date)*	12b. CHECK ☐ Total ☐ Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*

13. BOARD CERTIFIED? *(If yes, give name of Board(s))* ☐ Yes ☐ No

15. Current Hospital Privileges

a. NAME OF HOSPITAL	b. LOCATION	c. TYPE OF APPOINTMENT

16. Interval Information ***(If Yes to any of the following questions, give full details on a separate sheet of paper.)***

In the last year, have you:	YES	NO
a. Have you had any final unfavorable liability judgments?		
b. If yes, any liability payments above $100,000?		
c. Have you been the subject of **any** disciplinary action by **any** local or state medical society or **any** licensing agency?		
d. Have you had your clinical privileges limited, revoked, or otherwise modified at **any** institution?		
e. Resigned from the staff of any hospital?		
f. Been treated for drug or alcohol abuse?		
g. Not maintained your state's continuing medical education requirements?		

	YES	NO
h. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Outpatient Clinic**?		
i. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Emergency Care area**?		
j. Do you certify that you are mentally and physically able to practice medicine?		

17. COMMENTS

The information contained herein is true to the best of my knowledge and belief.	18a. SIGNATURE OF APPLICANT	18b. DATE

SECTION C - ARNG OR USAR UNIT COMMANDER'S RECOMMENDATIONS

That clinical privileges be granted to the named applicant for Active or Inactive duty.

1. NAME

2. PERIOD

FROM | TO

3. MEDICAL TREATMENT FACILITY OR DENTAC

4. BY EDUCATION AND TRAINING, THIS PRACTITIONER IS QUALIFIED IN THE FOLLOWING

SPECIALTIES	UN-KNOWN	YES	NO
a. Primary →			
b. Secondary →			
6. This practitioner has the capability of performing the medical duties required of a General Medical Officer or General Dentist.			
7. All documents of education, training, licensure/certification/registration and ECFMG (if applicable) have been verified with a primary source.			

5. PRACTITIONER'S DEMONSTRATED CLINICAL COMPETENCY REMARKS

8a. NAME OF VERIFYING INDIVIDUAL | 8b. GRADE | 8e. SIGNATURE

8c. TITLE | 8d. DATE

9a. NAME OF UNIT COMMANDER | 9b. GRADE | 9e. SIGNATURE

9c. TITLE | 9d. DATE

SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE

10. REMARKS

11. RECOMMENDED STATUS

☐ Conditional ☐ Full

12. CLINICAL PRIVILEGES RECOMMENDED

☐ As Requested ☐ Other *(Specify in Item 12.)*

13a. NAME OF CREDENTIALS COMMITTEE CHAIR | 13b. GRADE

13c. SIGNATURE | 13d. DATE

SECTION E - APPROVING AUTHORITY

14a. NAME OF MTF OR DENTAC COMMANDER | 14b. SIGNATURE | 14c. DATE

MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-68, the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:: Title 5, United States Code (USC), Sections 3109 and 3301. *(Title 5, USC, Section 552a).*

Principal Purpose: To obtain U.S. Civil Service appointment.

Routine Uses: Basis for determination of qualifications and background information for the eligibility for appointment. Basis for credentialing health care providers.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information will result in nonacceptability of the application.

The policy of the Army is to screen, verify and validate statements, assertions and documents of all applicants for health care provider positions. As part of this process, please complete the following statements *(as applicable to your profession).*

1 NAME OF INDIVIDUAL	2 SOCIAL SECURITY NO *(SSN)*

HAVE *(YES)*	HAVE NOT*(NO)*	
		3. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice. *(If affirmative explain each incident in item 13 below.)*
		4. I am licensed/registered/certified by the authority named in item 13 below. *(List all current and past licensures held (include issue and expiration date). Explain the circumstances surrounding the suspension or revocation of licensure previously held.)*
		5. Had my professional license denied, withdrawn, or restricted by a state or local licensing board or other authority. *(If affirmative, give the organization name, address, and dates involved in item 13 below.)*
		6. Had professional privileges denied, withdrawn, or restricted by a health care facility. *(If affirmative, give the organization name, address, and dates involved in item 13 below.)*
		7. Resigned or otherwise disassociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. *(If affirmative, give the organization name, address and dates involved in item 13 below.)*
		8. Are you now or have you ever been required to appear before any medical or state regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? *(If affirmative, give brief explanation in item 13 below.)*
		9. Had a history of drug or alcohol abuse or misuse. *(If affirmative, explain in item 13 below.)*
		10. Do you have any disease or impairment which would make your employment a hazard to yourself or others? *(If affirmative, please list in item 13 below. In addition, please provide a brief description of your health status.)*
		11. I hereby authorize the U.S. Army to contact my malpractice carrier/licensing organizations for the purpose of verifying the above information.

11a. CARRIER *(Name and Address)*	11c. LICENSING ORGANIZATION *(Name and Address)*
11b. POLICY NO	

		12. I hereby authorize the U.S. Army to contact the following institution(s) for the purpose of verifying the status of my current professional privileges:

12a. ORGANIZATION *(Name and Address)*	12b. DATE*(S)*

13. CLARIFICATIONS, EXPLANATIONS, ETC., REGARDING ITEMS 3-10 ABOVE. *(Identify by appropriate item number.)* *(Continue on reverse side if necessary.)*

14a. TYPED/PRINTED NAME OF APPLICANT	14b. SIGNATURE OF APPLICANT	14c. DATE

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